CUMBERLAND COUNTY COUNCIL

(Education Committee)

LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE
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ANNUAL REPORT

of the

PRINCIPAL SCHOOL MEDICAL OFFICER

W. H. P. MINTO, M.D., D.P.H.

on the

SCHOOL HEALTH SERVICE

FOR THE YEAR 1958

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PREFACE

To the Chairman and Members of the Education Committee

Mr. Chairman, My Lord, Ladies and Gentlemen,

I have the honour to present the annual report on the school health service for the year 1958.

I referred last year to the magnificent part the teachers in the county had played in securing the registration of so many children for vaccination against poliomyelitis. Thanks to their continued efforts and those of the staff, both professional and lay, of the school health department, by the end of 1958, over 80% f all Cumbrian school children had been registered and 97% of these had received wo or more doses of poliomyelitis vaccine.

In spite of the effort required to produce this achievement, the normal programme of routine medical inspections was completed in all but six schools. However, even with the assistance of six additional part-time medical officers mployed on a sessional basis, it was found impossible to maintain the high level f diphtheria immunisation which must have been the major factor in Cumberland's omplete freedom from that disease for ten years.

The scheme for deaf and partially deaf children is now well established and include a full report on this year's progress in audiometry. This has brought o light some interesting facts about the extent of varying degrees of deafness among chool children. The first peripatetic teacher of the deaf took up post in September nd he has now made close contact with pupils, teachers and the different members f the ascertainment and guidance teams.

The guidance clinics for the physically handicapped, started initially for stics, have underlined again the importance of this kind of teamwork in the hool health service. With adequate parent guidance and teacher co-operation it very encouraging to find how many seriously handicapped children become able attend profitably an ordinary school.

Most of the remaining cases of major handicap are nowadays of a congenital hereditary nature and if these are to be prevented in future generations there is ed for much careful research for which the school health service seems most ited. The first essential is knowledge acquired by patient study of new methods d of the new problems. This requires adequate inservice training for all grades staff, with regular meetings for exchange of views and attendance at suitable st-graduate courses of instruction.

Given knowledge, the next and perhaps the greatest and most pressing prob- n is its dissemination. This task, by Health Education in its widest sense, is a most proper and vital one for the school health service in the closest liaison with the other members of the team—parents, teachers and family doctors. It is probable that as future plans for further education develop there will be increasing scope for thoughtful education in healthy living for children of all ages in the schools in Cumberland.

I must again express my thanks to Dr. Machell for the part he has played in the preparation and production of this report and to all members of the medical, dental, nursing and clerical staff for their loyal support in a hard year's work.

I am, Mr. Chairman, My Lord, Ladies and Gentlemen,

Your obedient servant,

W. H. P. MINTO,

Principal School Medical Officer

County Health Department,
11 Portland Square,
Carlisle.

January, 1959.

SCHOOL HEALTH SERVICE

STAFF AS AT 31.12.58

SCHOOL MEDICAL AND DENTAL STAFF AT 31st DECEMBER, 1958

Principal School Medical Officer:—

*W. H. P. Minto, M.D., D.P.H.

Deputy Principal School Medical Officer:—

*R. K. Machell, M.B., Ch.B., D.P.H.

School Medical Officers:—

*John Neil Dobson, M.B., Ch.B., D.P.H.) Also District
John R. Hassan, M.B., Ch.B., D.R.C.O.G.) Medical Officers
(Part-time General Practitioner)) of Health
*James L. Hunter, M.B., Ch.B., D.P.H.) and
*Isaac S. Jones, M.R.C.S., L.R.C.P., D.P.H.) Assistant County
*John Patterson, M.B., B.Ch., B A.O., D.P.H.) Medical
*Ethel A. Perrott, M.D., B.S., D.P.H.) Officers
*Kenmure J. Thomson, M.B., Ch.B., D.P.H.)

*Enid M. O. Campbell, M.B., Ch.B., D.P.H.)
*Catherine Helen Mair, L.R.C.P., L R.C.S.(Ed.), D.P.H.)
*Percy Thomas Regester, M.R.C.S., L.R.C.P., D.P.H.) Also
) Assistant
Elizabeth Davison, M.B., B.S. (part-time - sessional basis)) County
James L. Hardie, M.B., Ch.B. (,, ,,)) Medical
Mary A. Marshall, M.B., Ch.B. (,, ,,)) Officers
Cynthia Mawson, M.B., B.S. (,, ,,))
Edith M. M. Reid, M.B., Ch.B. (,, ,,))
Diana Pratt Yule, M.B., Ch.B. (,, ,,))

*Approved by the Ministry of Education for the ascertainment of educationally subnormal pupils.

Principal School Dental Officer:—

A. C. S. Martin, L.D.S.

School Dental Officers:—

I. R. C. Crabb, L.D.S.
D. H. Hayes, L.D.S.
Mrs. M. Hayes, B.D.S.
F. H. Jacobs, L.D.S.
D. C. Lamond, L.D.S.
R. B. Neal, M.B.E., L.D.S.
A. R. Peck, L.D.S.
A. M. Scott, L.D.S.

MEDICAL AUXILIARY STAFF

Orthoptist:—

Mrs. J. Scott, D.B.O. (nee Hodgson). Became part-time 31.12.57 on resignation.

Miss A. Murray, D.B.O. Commenced 3.2.58.

Orthopaedic Physiotherapists:—

Miss J. M. Morris, M.C.S.P., M.E.

Miss J. A. Fraser, M.C.S.P., O.N.C.

Speech Therapists:—

Mrs. J. M. Moss, L.C.S.T. (resigned 31.7.58).

Miss A. M. Stevenson, L.C.S.T. (resigned 10.10.58).

Mrs. S. E. Latimer, L.C.S.T. Part time from October, 1958.

Miss C. C. Richardson, L.C.S.T. (commenced 1.9.58).

NURSING STAFF

Superintendent Nursing Officer:—

Miss I. Mansbridge, S.R.N., S.C.M., Q.N., H.V.Cert.

Deputy Superintendent Nursing Officer:—

Miss S. Keeler, S.R.N., S.C.M., Q.N., H.V.Cert. (resigned 10.2.58).

Miss I. John, S.R.N., S.C.M., Q.N., H.V.Cert. (commenced 1.4.58).

Assistant Superintendent Nursing Officers:—

Miss P. G. O'Sullivan, S.R.N., S.C.M., Q.N., H.V. Cert. (commenced 1.2.58).

Mrs. A. Steele, S.R.N., S.C.M., Q.N., H.V.Cert.

Three full-time school nurses

62 nurses and health visitors doing part-time school nursing, of whom 29 hold the Health Visitor's Certificate.

GENERAL STATISTICS

The area covered by the Local Education Authority comprises 967,054 acres and the estimated population of the Administrative County in June, 1958, was 217,700.

The number of pupils on the school registers in January, 1959, was 36,944 compared with 36,607 in the previous year, an increase of 337.

In January, 1959, there were in the county:—

		No. of Pupils
Nursery School	1	40
Primary Schools	251	25,125
Non-Selective Secondary Schools	19	7,303
Grammar Schools	9	4,093
Secondary Technical School	1	292
Residential Special Schools	2	
(One for educationally subnormal boys, age range 9-16 years)		55
(One for educationally subnormal girls, age range 9-16 years)		36

MEDICAL INSPECTION

Routine age groups were examined as in previous years with the exception of the " leavers " in the grammar schools. During 1958 the same group of children in grammar schools was examined as leavers as in secondary schools, that is children born in 1944. The other groups examined were primary school entrants and the ten year old children (born 1948). The vision of all 8 year old school children (born 1950) was tested.

The school medical officers carried out a complete medical inspection in all schools in the county with the exception of 6 schools which could not be visited owing to the extra commitments involved in carrying out a large programme of vaccination against poliomyelitis.

The statistical tables relating to medical inspection are set out as Appendix A at the end of this report. The detail contained in Appendix A differs from that presented in the previous years in that periodic examinations are now recorded in actual years of birth.

Findings at Periodic Medical Inspection

Periodic medical inspection was carried out on 10,887 pupils and of these 1,286 were found to be suffering from defects for which treatment was recommended, giving a percentage of 11.8%.

Comparative figures for the last 7 years are of interest

	Total Periodic Examinations	Total pupils found to have defects	%
1957	10,864	1,302	11.9
1956	9,783	1,352	13.8
1955	8,691	1,632	18.8
1954	9,920	1,394	14.1
1953	9,747	1,569	16.1
1952	9,759	1,673	17.1
1951	8,675	1,412	16.3

Physical Condition

From 1956 the Ministry of Education directed that a school child should be placed in one of two categories — " satisfactory " or " unsatisfactory " — according to the child's physical condition. This replaced a previous classification into one of three categories " good ", " fair ", and " poor ". The trend since the introduction of this new procedure is shown in the table below.

	Total Examined	Total Found Unsatisfactory	%
1956	9,783	247	2.52
1957	10,864	132	1.22
1958	10,887	97	0.89

This division into two categories is useful in that the doctor is able to make an assessment of the individual child's capacity in its own environment rather than to attempt to measure it up against a quite mythical average, and the decline in the children considered " unsatisfactory " is pleasing. However, the need to continue assessment of the general health of school children in the widest sense is emphasised by Dr. Mair's report: —

" Few of the five year olds are not bursting with health. They look alive with twinkling eyes, they have an unselfconscious curiosity about the person examining them, they have clear skins and firm flesh and are just full of energy. That is the rule with the five year old. By the time the ten year old examination comes along, few children are healthy to that extent. There is no physical defect, but they are no longer bursting with health. By fourteen such a picture is rare. One sees perhaps one such young person in a whole day. Somewhere between the ages of five and ten the school health service is failing to help parents to keep their children positively healthy."

Cleanliness

The school nurses are authorised to examine the person and clothing of any child attending school, and arrangements are made for routine inspections for this purpose. The school nurse not only follows up these cases, but reports to the school medical officer where necessary.

The school nurses made 72,691 examinations of children for verminous conditions and uncleanliness, compared with 76,513 in 1957, and of this total 1,010 (1,029 in 1957) children were found to suffer from infestation.

Treatment of this condition nowadays is extremely simple and effective and with a little supervision by the nurse even the most unskilled parent can undertake it with complete success. There is still a hard core of families who will not keep their children free from lice, with the result that infestation can spread from these children to those of better kept families. Dr. Campbell refers to this problem in her report:—

"There is a curious tendency on the part of certain parents to believe that adults are immune to head infestation and that although their children are infested they themselves and the adult members of their family are free. This fallacy leads to a great deal of difficulty in treating children with infested heads owing to the fact that even when the condition has been cleared up in the child he returns to school in a very short time reinfested through contact with the rest of his family."

Following Up

There was no change in the procedure whereby the school nurses follow up children who are found at medical inspection to be in need of treatment for a defect. Visits undertaken for this specific purpose were as follows:— 145 visits paid to 105 cases.

Condition	No. of cases	No. of visits paid
Eye Conditions	22	33
Skin diseases	14	21
Nose and throat conditions	3	3
Ear conditions	25	26
Heart and circulation	—	—
General cases	38	57
Uncleanliness	3	5
	105	145

Employment of Children Bye-Laws

The original bye-laws, made in May, 1935, under the Children and Young Persons' Act, 1933, laid down the times and conditions under which children over the age of thirteen but not over compulsory school age might be employed, and listed prohibited employments as well as governing participation in entertainments and street trading.

Agricultural work involving heavy strain (i.e. lifting, carrying or moving anything so heavy as to be likely to cause injury), work under the control of a gang master, and work in connection with race tracks are added to the prohibited employments. Employment under certain conditions for an hour before school is now provided for in the revised bye-laws and a child may not work for more than three hours continuously on a Saturday or school holiday without a break of an hour and must be free for five hours continuously between the times of employment. An hour's light agricultural or horticultural work is to be permitted on a Sunday morning between 7 and 11 a.m. The previous bye-law made allowance only for the delivery of milk and newspapers. As well as being responsible for seeing that suitable clothing and footwear are provided against inclement weather, an employer is to be responsible for providing bicycle panniers for newspaper delivery where bicycles are used.

Until this year there had been no provision for medical examination but a clause has now been inserted requiring the employer to be furnished within 14 days of the commencement of employment with a medical certificate from the school medical officer stating that the proposed employment "will not be prejudicial to he health or physical development of the child and will not render him unfit to obtain proper benefit from his education." Similar certificates are to be required n January and July of each year.

ASCERTAINMENT AND TREATMENT OF DEFECTS

Minor Ailment Clinics

The school health service clinics available are set out in Appendix C to the report. A total of 2,820 individual children attended the school clinics during the year, attendances at individual clinics and the types of case are set out below.

Clinic	New Cases	Attendances All Cases
Alston	38	103
Aspatria	239	514
Brampton	138	264
Carlisle	99	151
Cleator Moor	99	636
Cockermouth	276	384
Egremont	76	178
Frizington	80	170
Keswick	14	19
Maryport	128	342
Millom	231	907
Penrith	87	203
Whitehaven (Mirehouse)	43	105
Whitehaven (Sandhills Lane) ...	114	456
Whitehaven (Woodhouse) ...	103	1,270
Wigton	277	552
Workington	311	1,326
	2,353	7,580

Defect Code No.	Conditions for which child attended	New Cases	Attendances All Cases
1.	Cleanliness	5	11
2.	Infestation	73	219
4.	Skin Diseases	508	2,092
5.	Eye Diseases	380	1,237
6.	Ear Conditions	105	316
7.	Nose and Throat Conditions ...	124	205
8.	Speech defects	31	44
9.	Lymphatic Glands	3	18
10.	Heart	1	3
11.	Lungs	53	216
12.	Developmental	—	1
13.	Orthopaedic	101	194
14.	Nervous System	10	62
15.	Psychological	27	51
16.	Abdomen	23	44
17.	Other Conditions	909	2,867
		2,353	7,580

While the number of school children attending formal minor ailment clinics is declining, in fact a far wider use is being made of these clinics for other purposes, including more selective medical examination of handicapped children and vaccination and immunisation.

Diseases of the Ear, Nose and Throat

The statistical information relating to diseases of the ear, nose and throat is set out in Table A and Table B, Pt. II of Appendix A. It is of interest that of the 128 cases of otitis media noted, 18 were found at medical inspection to require treatment, while of the 42 cases seen at special examinations, 22 required treatment.

Tonsillectomy

Continued provision has been made during the year to record whether or not each child at periodic medical inspection has undergone tonsillectomy at any time previously. The figures for Cumberland are as in the following table which also shows comparative figures for the years 1957 and 1956.

		Children who have had Tonsillectomy							
		1958				1957		1956	
Age Groups	Total Examined	Boys	Girls	Total	%	Total	%	Total	%
Entrants	3,579	119	118	237	6.6	251	7	360	9.5
Intermediate	3,538	488	443	931	26.3	1,025	27	897	27.3
Leavers	2,800	422	396	818	29.2	934	31	811	30
Additional Periodic	970	106	111	217	22.4	132	21	100	25.1
	10,887	1,135	1,068	2,203	20.2	2,342	21.6	2,168	21.3

Provision of Hearing Aids

The Ministry of Education require principal school medical officers to report for the year ending 31st December, 1958, the total number of pupils in schools who are known to have been provided with hearing aids: (a) in 1958, and (b) in previous years.

This information is set out in Table B. Part III of Appendix A.

Ascertainment and Treatment of Defective Hearing

The expansion of services for deaf and partially deaf children referred to in the 1956 and 1957 reports continues.

The audiometric room at Park Lane Clinic, Workington, was completed in the early part of 1958 and facilities exist there for —

1. Accurate tests of hearing of children from the earliest age.
2. Early auditory training for pre-school children.
3. Training children until full time education starts.
4. Parent guidance.

In September, 1958, the first peripatetic teacher of the deaf was appointed, Mr. Rawden who, since his training at the Department of Education for the Deaf, Manchester, had worked in schools for the deaf and partially deaf, was, on appointment, seconded for six weeks to the audiology unit at the Institute of Laryngology and Otology in London. The duties of the peripatetic teacher of the deaf, subject to revision in the light of experience are —

1. To provide direct teaching whenever appropriate.
2. To provide close liaison and continuity of guidance and training of all children of both school and pre-school age, who are ascertained deaf or partially deaf, by:—
    - (a) Visiting homes and advising parents.
    - (b) Visiting schools and giving specialist advice and teaching.
    - (c) Holding clinical sessions.
    - (d) Attending E.N.T. clinics conducted by the Local Health Authority.

The training of medical officers and health visitors in this work has continued and Dr. Mair reports in this connection as follows:—

" One noticeable feature has been that the numbers of children with a hearing loss have varied with the time of year. The numbers were high last spring and early summer, while in September and October few children with a slight loss were found. By December the numbers were again rising, the obvious explanation being the association of mild deafness with colds. I saw no new cases of severe deafness. Of the moderately deaf children there were two main groups — those with neglected middle ear disease, and those in whom the tonsils were enlarged and had a history of frequent colds, snoring and mouth breathing. The first group are likely to remain moderately deaf children, while the latter are likely to be found to have normal hearing after removal of tonsils and adenoids. In the cases of mild deafness the cause was usually a cold at the time of testing or wax. As with other handicaps or perhaps more so in the case of deafness, parents find it hard to believe their children are deaf. These children " get by " at home probably because they are shouted at or are just thought to be difficult and “didn’t want to hear.” To the parent it is inconceivable that their child cannot follow all that is being said in a noisy classroom.”

The following report by Dr. Hunter, Senior Assistant County Medical Officer in West Cumberland, outlines the work which has been carried out during the year.

“The ascertainment of defective hearing in school children was greatly extended during the year, this being made possible by the change from part to full-time employment of the audiometrician who had been trained in the Department of Education for the Deaf at Manchester University in 1957. In addition one health visitor, similarly trained, was employed on a limited part-time basis in the Workington area. By the end of the year all children in the year groups 1953 and 1952 in West Cumberland had been tested (a total of 3,645) and in addition about 800 in special groups. The apparatus used was the Pure Tone Audiometer.

“Experience in this form of assessment has shown that the test is easily applied to the vast majority of young children in school and is readily accepted by them. It was applied too in children of varying degree below average intelligence with apparently uniform results and was thought to be of some value in children attending the occupation centre. Even so, it was thought wise to duplicate many of the tests in the better conditions of the audiometric room in the Park Lane Clinic, Workington.

“The numbers tested were as follows: —

1. Routine groups —		
(i) Born 1953	1,781	
(ii) Born 1952	1,864	
	——	3,645
2. Outside routine age groups — i.e. older children		561
3. Special groups		
(i) Educationally Subnormal		
In ordinary schools ...	136	
In special schools ...	53	
(ii) Children with speech defects	10	
(iii) Children in Occupation Centre	29	
	——	228
Total tested in 1958 ...		4,434

" The survey was primarily aimed at new entrants to the infant classes but it was obviously more economical to cover two year groups, particularly on visits to small schools and bearing in mind that about twenty five children can accomplish the test in one session. In addition head teachers were asked to present for testing at the visit of the audiometrician, any children whose acuity of hearing was in doubt.

" Defective hearing was presumed to be present at a *minimal* loss of 20 decibels in two frequencies in one or both ears. From this basic standard were set the three categories of deafness used in the tables for purposes of classification into severe, moderate and mild degrees of bilateral and unilateral deafness. Thus a " mild " case ranges from a few losses at about 20 decibels to a similar loss throughout the range of frequencies; a " moderate " case contains losses around the 40-50 decibel-loss mark; and a " severe " case has significant deafness beyond a 50 decibel loss throughout the full range of frequencies.

" The clinical follow-up was two-stage. (a) A clinical examination by the School Medical Officer in the school clinic (and sometimes in the audiometric room), and (b) an examination by the ear, nose and throat specialist. The clinical examination by the School Medical Officer included an enquiry into possible origin of the deafness, e g. family history, conditions that might have put the child " at risk ", (prematurity, birth trauma, etc.) and illnesses that might have been causal to deafness. Such findings, and a note of any abnormal conditions found in the ear, nose and throat were passed in appropriate cases to the ear, nose and throat surgeon. A supplemental enquiry into the incidence of prematurity in the *routine* groups tested was made by a study of the Premature Birth Registers for the years 1952 and 1953. A fair proportion of the cases will require further supervision, after diagnosis by the School Medical Officer, by the otologist, by the teacher in school and by the teacher of the deaf.

" It should be appreciated that the period of one year cannot cover the complete history of all cases and no table or annual survey can show in simple fashion all the stages in assessment, treatment and end result. Cases were being added to the list up to the last day of the year in which the survey took place. The "Main Table" (see attached to back cover) merely purports to show the number of cases of deafness or probable deafness in various categories of severity in the routine group and others tested in school, possible factors in the cause of deafness, the findings of the School Medical Officer and otologist and the results of retesting in the few who had reached that stage by the end of the year. Of 3,645 children born in 1952 and 1953, 224 (6.1%) were found to have some degree of hearing loss; about one-fifth of these cases were already known to have difficulty in hearing before the tests were made but the rediscovery served in some cases to further elucidation of cause and hasten treatment. Only three cases of apparently severe deafness were brought to light — one was thought by the School Medical Officer to require simple observation because there was no clinical reason apparent and the child appeared to be backward. The two others both required attention to tonsils and adenoids and one had had severe middle ear disease.

"All eleven cases of moderate bilateral deafness were seen by the School Medical Officer — permaturity may have been the cause in one, meningitis was in another. All were referred to the otologist. Two with wax and one with catarrh gave normal response to the test after treatment. Two of the four moderate unilateral cases were investigated — in one there was a history of a discharging ear; in the other wax was probably responsible. There were 171 new cases of mild unilateral or bilateral deafness in the routine group. Over one hundred cases were quickly resolved into cases for simple observation (probably catarrhal otitis) or of treatment for wax, etc. Twenty-three required the opinion of the otologist and eight were seen by him before the end of the year. There were no severe cases among the "routine-already-known" group. The six moderate cases gave histories of kernicterus (1 case), anomalous growth (1 case) and anoxia after birth (1 case). Two of the six consulted the family doctor, two were seen by the otologist (one being recommended for a hearing aid and one for auditory training). The two unilateral moderate cases were caused by injury to the skull and chronic otitis media. Cases outside the routine group, i.e. born before 1952 (totalling 106 — 19.0% of number examined) contained a higher proportion of already known cases — nearly one-third. Many of these were presented by head teachers because they were suspected or known to have defective hearing. Otitis media was the main cause of deafness in this group and six were already wearing hearing aids. Thirty-seven were referred to the otologist and two more were recommended hearing aids and two auditory training.

"Of educationally subnormal children tested in ordinary schools — 13 children of a wide range in age — twelve were found to have hearing losses of which eight were mild unilateral or bilateral cases, one had a moderate loss in both ears at high frequency, two moderate losses at all frequencies in both ears and one severe case already known before testing and wearing a hearing aid. Twenty-nine children in the occupation centre were tested and three were thought to be deaf — two in mild degree. The third case showed moderate losses in both ears. This child is in fact a border-line case of mental defect who, on repeated intelligence tests, has shown a slight rise in response and one wonders if the improvement is correlated with greater facility in lip-reading as he gets older. The case will be referred to the otologist for further investigation.

"Prematurity is a recognised factor in the production of deafness. Of 24 premature children born in 1952 and 1953 ten appeared among the newly discovered cases of hearing loss. The sole case of severe bilateral deafness (already mentioned lid not appear to be markedly deaf on ordinary clinical examination and speech vas normal. This case will be kept under observation. The moderately deaf case both ears) gave no history of deafness but has been referred to the otologist Of the remaining cases only one required referral to the otologist.

“There are two main approaches to the ascertainment of deafness in child-en, (a) by early ascertainment of *all* children before school age and on entering chool and (b) by careful ascertainment of those known to be at risk, that is, known o have some factor in their history that would make deafness likely to appear e.g. prematurity, German measles in the mother at an early stage of pregnancy, amily history of deafness). Whichever approach is employed more than one *nethod* can be applied. Screening for deafness by word tests can be used in chool children without any special apparatus. The method may be a good, if not ndispensible, supplement to testing with a pure-tone machine.

“The survey in 1958 was successful in that it brought to light a number of ases of deafness which otherwise might have escaped recognition and set in motion eeded treatment. It is felt that greater probes could be made into the etiological actors in deafness — prematurity as one factor emerged more from a study of he birth register than from the taken history.”

Visual Defects and Diseases of the Eye

The findings at medical inspection are set out in Table A. Pt. III of Appendix ., and the arrangements for the provision of spectacles are unchanged. A routine ve test is carried out for each child who has a periodic examination, letter “E” pe test cards being available for testing the entrant periodic group, and in addition ach 8 year old child has a routine eye test.

efective Colour Vision

Since it was started in late 1956 the testing of the colour vision at the school aving examination has been carried out over a wide area in the county. The cent figure does not differ materially from that of the former narrow survey. he most recent figure shows 8.3% incidence amongst boys of colour blindness all its forms, as against the previous finding of 7.7%.

Dr. Regester, who takes a special interest in this work, reports as follows: —

“Experience does suggest a small refinement of the technique of testing th the Ishihara charts. A look of consternation appears on the face of the uth informed that he is partially colour blind and therefore unable to “see lours as well as other people.” He quite obviously was unaware until that moment that colour vision was in any way distinguishable from visual acuity or ‘eyesight.’ Furthermore, he has just been told to doubt the commonsense veracity of the old adage ‘seeing is believing.’ Therefore it has been found desirable after finding the defect to test a boy with normal colour vision while the colour-blind pupil looks on. Not only does this bring full realisation of his idiosyncracy to the boy who is truly colour-blind, but it enables the examiner to check the degree of his inability to read the numbers on the charts; occasionally the boy shows that he can, when concentrating, see the figures and is in fact not strictly colour-blind for greens or reds as first assumed. Often when the pupil is to take up jobs, like farming, the defect will be no handicap. Nevertheless he is warned about how it might affect him in ordinary life and advised not to be too dogmatic where colour judgments are involved. Suitable advice is given, for example how luminosity and relative position often allow him to distinguish lights such as traffic signals.”

Ascertainment and Treatment of Squint

Mrs. Scott resigned as full-time orthoptist on 31st December, 1957, but agreed to carry on part-time on a sessional basis until Miss Murray took up post on the 3rd February, 1958. Miss Murray reports:—

“Throughout the year Mrs. Scott has lent invaluable assistance whenever possible but notwithstanding it has not been possible to give full attention to all those school children requiring orthoptic treatment. Although patients on the whole are attending at an earlier stage than in previous years it cannot be too greatly emphasised that children must be referred to the ophthalmic surgeon as soon as possible after onset of squint is noticed, because of secondary complications developing. This means that any report of suspected squints from parents, teachers or health visitors can be investigated thoroughly.

“For treatment with the synoptophore to be effective a child must attend regularly and training a child to use both eyes equally in the fusion of objects and later the development of a sense of perspective is time-consuming work that cannot be hurried if lasting benefit is to be obtained.

“County children were treated throughout the year at the clinics at Portland Square, Carlisle, Park Lane, Workington, and, since July, 1958, at Brunswick Square, Penrith, as well as at sessions at the Cumberland Infirmary and Whitehaven Hospital. It would be a great benefit if time could be found for regular weekly sessions to see children wearing occluders on their spectacles, in order to assess any improvement in vision and renew or adjust patches, as this forms such a vital part in the successful treatment of squint.

"In view of the heavy and costly equipment necessary it is only possible to carry out treatment in the major clinics and there is room for more conviction on the part of parents that the ultimate benefits, psychologically as well as cosmetically, justify the travelling involved. Perhaps teachers and family doctors, in addition to health visitors, can do much here to reinforce this point of view whenever the opportunity arises."

Skin Diseases

The number of children referred for treatment of diseases of the skin during 1958 was 601, which represents a decrease of 35% on the previous year's figure.

Orthopaedic and Postural Defects

Consultant clinics were held as shown in Appendix C and the orthopaedic scheme remains unchanged. The orthopaedic physiotherapists, Miss Morris and Miss Fraser, report as follows: —

" The work in the orthopaedic clinics has continued through the year without much change. The attendances at clinics have remained fairly good. The number of home visits tends to increase especially in dealing with the seriously handicapped child, as it is essential to know their home surroundings. It has been found that more co-operation can be obtained by the seriously handicapped child doing exercises in his own home than is possible in the clinic."

Orthopaedic Treatment undertaken during the year

Number on Aftercare register at 1.1.58.	1,228
New cases during 1958	90
Cases referred for Orthopaedic Physiotherapist only	121
Cases renotified after previous discharge	10
Cases attaining school age after having been referred originally from Child Welfare Clinic	99
Number removed from Register	339
Number on Register at 31.12.58	1,209
Attendances at surgeons' clinics	673
Attendances at intermediate clinics	2,288
Homes visited by Orthopaedic Physiotherapists	475
Plaster applied	40
Surgical boots and appliances supplied and renewed (including insoles)	467
Cases receiving hospital treatment during 1958	45
Cases awaiting admission to hospital 31.12.58	29
X-ray examinations during 1958	81
Awaiting X-ray	38

Number on Aftercare Register at 31.12.58

Flat foot	332
T.B. Joints	23
Injuries (including fractures)	11
Poliomyelitis	54
Knock knees and bow legs	315
Cerebral palsy	62
Other birth injuries	11
Torticollis	8
Spina bifida	9
Pseudocoxalgia	2
Perthes disease and coxa vara	19
Congenital dislocation of the hip	31
Congenital defects (including talipes and pes cavus)	103
Hallux valgus and deformed toes	38
Postural defects	82
Scoliosis, lordosis and kyphosis	18
Achondroplasia	3
Muscular distrophy	3
Schlatter's disease	1
Osteomyelitis	2
Arthritis, synovitis, rheumatism	4
Slipped epiphysis	3
Other conditions	75
	1,209

There are always some children who cannot touch their toes without bending their knees. It is not perhaps widely enough realised yet that there is growing evidence that definite harm may be done by forcing such children to over-flex the spine. Under certain circumstances, as for example when the ham-string muscles are naturally tight, excessive flexion may be a predisposing factor to the condition of osteochondritis in adolescents, in which the bodies of spinal vertebrae degenerate and the intervening space is narrowed, and there may well be a relationship between damage to the spine in adolescence and the "slipped disc" of later life.

Speech Therapy

Miss Richardson, full-time speech therapist reports:—

"Mrs. Moss resigned in July, and Miss Richardson was appointed in September this year. In October Miss Stevenson also resigned so that only one speech therapist remained to cover the whole county. However, since October, Mrs. Latimer has once again held one clinic a week in Carlisle, which has helped to ease the situation.

"Some clinics have unfortunately had to be curtailed; these are Millom, Seascale, Mirehouse, Aspatria, Keswick, Ingwell School and Higham. Otherwise clinics have been held as usual in Carlisle, Maryport, Wigton, Penrith, Workington, Whitehaven, Egremont and Cleator Moor, but many patients are only seen once a fortnight.

"The waiting list has increased considerably, owing to the shortage of speech therapy staff, and school, and home visiting has also been curtailed. Consequently the attendance of some children has been very poor, as school and home visits tend to make attendance more regular.

"It is hoped that 1959 will see the speech therapy staff at its full quota of three, so that work over the whole county can be satisfactorily maintained.

"The number of patients stood down owing to the curtailment of certain clinics are included on the waiting list."

	On Register 1.1.58.	Discharged	Admitted	On Register 31.12.58.	Waiting List
West Cumberland	115	27	40	126	132
East Cumberland	95	43	77	95	114

Particulars of Cases Discharged

	West Cumberland	East Cumberland
Normal	15	29
Greatly improved	3	3
Improved, unlikely to benefit further ...	—	3
Unimproved, unlikely to benefit further ...	2	—
Lack of co-operation	5	2
Transferred	2	6

Cases Treated

	West Cumberland	East Cumberland
Dyslalia	71	44
Stammer	32	46
Stammer and dyslalia	4	3
Sigmatism	12	8
Cleft palate	6	6
Hard of Hearing	5	6
Dysarthria	3	1
Dysphonia	1	—
Aphasia	1	15
Retarded speech	2	33
Excessive nasality	—	3
	137	145

Attendances

	Attendances	Waiting List
Cleator Moor	224	8
Egremont	243	15
Millom	307	23
Whitehaven	645	25
Workington	908	23
Seascale	19	—
Penrith	193	17
Aspatria	53	5
Maryport	153	19
Keswick	81	1
Wigton	242	9
Carlisle	496	27
Higham	69	—
Total attendance	3,633	

Child Guidance

As will be seen from the following statistical table on the work of the Child Guidance Centres during 1958, the number of new cases referred during the year (80) remains substantially at the same level as for the past five years.

For the first time for some years the teams (consisting of Psychiatrist, Educational Psychologist and Social Worker) at all the Centres have continued unchanged in personnel. This, however, does not give a true reflection of the staffing situation because the West Cumberland clinics, whilst admirably served by a part-time social worker for the equivalent of two whole days per week, have had a vacancy for a fully trained whole-time psychiatric social worker since January, 1955, and it has not been possible to fill this position because of the tremendous shortage of this type of worker.

The importance of the psychiatric social worker in the Child Guidance team cannot be over-estimated. The success of Child Guidance treatment largely depends on securing and maintaining the full co-operation not only of the patient, but of the family unit as a whole in treatment, and this is the particular function of the psychiatric social worker. Because of this failure to recruit a psychiatric social worker, as mentioned in my last report, it was suggested that the Authority should subsidise a student in training for psychiatric social work. The County Council has now approved a scholarship scheme and it is hoped to send a student possessing the necessary basic qualification and with some acceptable experience in field work for the academic year's training at one of the approved university courses, commencing in September, 1959. After qualification and as a condition of contract, the student will be required to remain in the Authority's service for a minimum period of two years. This scholarship scheme should continue until our requirements in the way of psychiatric social workers, not only for Child Guidance purposes, but for an expanding field of domiciliary mental health work, are fully met.

CHILD GUIDANCE CENTRES — STATISTICAL RETURN FOR THE YEAR ENDED 31.12.1958.

STAFF:	Carlisle	Maryport	Whitehaven	Millom	
Psychiatrist	Dr. Stuart	Dr. Ferguson	Dr. Ferguson	Dr. Ferguson	
Educational Psychologist	Mr. H. Blair Hood	Mr. H. Blair Hood	Miss Grey	Miss Grey	
Psychiatric Social Worker	Miss M. Lamb	Mrs. M. M. Coles	Mrs. M. M. Coles	Mrs. M. M. Coles	Total
Cases remaining on register at January 1st, 1958	29	46	126	9	210
New cases referred during year by:—					
Consultants or General Practitioners	7	5	18	—	30
School Medical Officers	4	1	15	—	20
Children's Officer	4	—	—	—	4
Parents	1	—	3	—	4
Schools	11	—	4	1	16
Probation Officers or Courts	—	—	2	2	4
Others	—	—	2	—	2
Cases re-opened during year	2	1	1	2	6
Total cases on registers during year	58	53	171	14	296
Cases dealt with and closed	26	32	25	2	85
Cases remaining under treatment at 31.12.1958	25	21	143	12	201
Cases awaiting treatment at 31.12.1958	7	—	3	—	10
	58	53	171	14	296
Interviews by Psychiatrists:					
(a) with child and/or parent	159	108	204	19	490
Interviews by Social Workers:					
(a) At Home	31	6	178	8	223
(b) At clinics	36	—	8	—	44
(c) Others	—	—	—	—	—
Interviews by Educational Psychologist:					
(a) Tests, play therapy, remedial teaching, etc. with child	29	84	233	11	357
(b) School visits	42	25	63	4	134
(c) With parents at home or clinic	—	12	12	3	27

Handicapped Pupils

Whatever experiments may be made in apportioning the time spent on periodic medical inspections, there is no doubt that school medical officers will in the future need to spend more time on the individual pupil suffering from one or more of the categories of handicap. The special report forms 2 H.P. and 4 H.P. should, if used correctly, represent not a brief impersonal document among a file of papers about a child, but the culmination of many months, possibly years, of observation of a child's attempts to come to terms with his handicap, and to develop physically, intellectually and emotionally in the atmosphere of his own home and the ordinary school. Apart from reports from psychologists, teachers and health visitors, there must be adequate and regular interchange of information with consultants and family doctors if the school medical officer is to form an accurate assessment of the type of special educational treatment required.

In this county, in the case of handicaps other than educational subnormality, a recommendation for admission to a special school involves going away to residential schools outside the county, and the table on page 38 sets out the present distribution of Cumberland children in residential special schools. Such a recommendation naturally causes a parent to press for alternatives and a school medical officer must be confident that a high standard of collaboration exists between all concerned before advising a parent that an adequate educational alternative exists in a progress class, in attendance at ordinary school with the provision of transport or, in the case of certain physical handicaps, remaining at home and receiving home tuition.

While from the educational standpoint the feasability of educating a handicapped child in an ordinary school will depend on the time teaching staff can devote to the child without prejudicing the interests of other pupils, the success or otherwise of remaining at home will, from the medical aspect, depend upon the availability within accessible distance of the school or home of ancillary services such as physiotherapy, speech therapy, orthoptist clinics, child guidance clinics and facilities for the guidance of the partially deaf. Much too will depend upon the degree of support the handicapped child will receive from his own family, and while school medical officers, who are also medical officers of health, are in a particularly strong and knowledgeable position as to the households in their districts, there is need for much painstaking and often unrewarding case work in the homes by health visitors and workers in the mental health field. In this connection it is a highly satisfactory arrangement that medical officers in mixed appointments are also chairmen of committees in their areas formed to consider children neglected in their own homes, and the prevention of break-up of families. The possibility can therefore always be borne in mind of finding a good foster home from which the child can attend ordinary school, as an alternative to a problem family background which, apart from resulting in physical and moral neglect, serves often to aggravate the handicaps of the delicate, the maladjusted, the partially deaf child, and the child with a chronic chest condition or other physical handicap.

If, all things considered, residential special schooling is the method of choice the school medical officer must still maintain contact with the child during the holidays and ultimately when he leaves special school and has to face the real problem of employment as a disabled person in his own area. In this respect the value cannot be too highly stressed of the receipt by the sending authority of regular and comprehensive reports, medical as well as educational, from special schools, and it is perhaps not fully appreciated how vital to the interests of the handicapped child is the guidance which the school medical officer can give to youth employment officers, both informally and by reports on form Y. 10 as well as to Welfare Officers in relation to their services to handicapped persons under the National Assistance Act.

Blind and Partially Sighted Pupils

The problems of totally blind children are so specific and the methods used in their education so exclusive that no other alternative can at this present time compare with the facilities provided in a special school for the blind. The 5 Cumberland children in this category attend 2 schools in Shrewsbury and Newcastle, while there are 7 partially sighted children in 2 schools in Preston and Berkshire.

Reference to consultant ophthalmologists for completion of form B.D. 8 is arranged as early as desirable and the usefulness to school medical officers of these reports is beyond doubt, providing as they do, not only a recommendation as to special educational treatment, but also contributing information as to causation and prognosis, and indicating the period after which further examinations should be made.

In the case of the borderline partially sighted child in an ordinary school, nothing is so important as team work by health visitors, teachers and parents in ensuring that glasses are worn as recommended by the specialist, and in the event of damage are repaired as quickly as possible by making full use of the procedure under the Hospital Eye Service.

As hereditary conditions form a considerable proportion of the causes of blindness in children, treatment and education are likely to offer more for some years to come than any dramatic environmental at or preventive measures, though there is scope for more health education in the care of the eyes and the preservation of eyesight. The numbers and types of case making use of the orthoptic service are described in detail on page 22. As the contribution of orthoptics is more fully appreciated by parents, this service is likely to be far more widely patronised.

Deaf and Partially Deaf Pupils

The number of deaf and partially deaf children at special schools at the end of the year was 14. Once again I am indebted to Professor Ewing (now Sir Alexander Ewing) for his guidance over the educational needs of those children who, after consultation with consultant otologists, I periodically send to the Department of Education of the Deaf in Manchester, for full assessment.

In obtaining early information about hearing loss in children the two arms of the service still remain, firstly the screening tests by health visitors of young children, and secondly sweep audiometry of school children of entrant age, together with special cases referred by teachers, parents and others. The findings of sweep audiometry and the progress of the scheme in general during the past year are described on page 16.

Educationally Subnormal

The Authority maintains two special residential schools for educationally subnormal pupils — at Ingwell, Moor Row, for boys, and at Higham, near Cockermouth, for girls.

Ingwell school provides accommodation for 57 pupils and, of the places available, four are allotted for the use of pupils from the city of Carlisle and six for Westmorland boys. The girls' school at Higham has accommodation for 38 pupils, of which 32 are available for children from the county, the balance of six being equally divided for girls from Carlisle and Westmorland.

Six Cumberland children (two boys and four girls) are resident at special schools for the educationally subnormal outside the county. Three of these have a second handicap coupled with their educational subnormality and were admitted to out-county schools for this reason. One girl continues in attendance at the Birmingham school to which she was admitted before Higham school was opened, but in two cases (one boy and one girl) it was necessary to seek accommodation in schools outside Cumberland because places were not available at Ingwell and Higham.

From the table which follows showing the numbers of handicapped children in various types of special schools it will be noted that 79 pupils (45 boys and 34 girls) are receiving special educational treatment on account of educational subnormality in special residential schools. As a result of examinations carried out under Section 34 of the Education Act, 1944, during the year 1958 alone a total of 52 children were recommended for education in special schools for the educationally subnormal. It follows that the present facilities within the county for the special education of children suffering from this form of handicap cannot be regarded as adequate. The Education Committee hopes to increase the provision of special "progress" classes in ordinary schools, but the introduction of these facilities (and the continuance of such classes when established) may present difficulties because of staff shortages and accommodation problems.

Although the statutory school leaving age for pupils in attendance at special schools is 16 and parents accepting places at Ingwell and Higham give a written undertaking to allow their children to remain at school until 16, 3 boys (2 in 1957) were withdrawn from Ingwell school during the year before reaching the special school leaving age as laid down in the Education Act for children on the register of special schools.

2 H.P. EXAMINATIONS COMPLETED IN 1958

Under Section 34

Recommended Special School—E.S.N.	52
do. —Maladjusted	1
do. —E.S.N. and Physically Handicapped ...	2
Recommended Special Class (E.S.N.)	6
No special educational treatment required	2
	63

Under Section 57

Reported as ineducable (Section 57(3))	17
Reported as requiring supervision on leaving school (Section 57(5)) ...	13
Decision as to educability deferred	8
Not requiring supervision on leaving school	6
	44

NEW CASES REFERRED IN 1958

Referred by	Referred for investigation of intellectual capacity	Referred for behaviour disorders	Referred as possibly ineducable	Total
School Medical Officers ...	59	28	1	88
Psychologists and Teachers ...	67	14	—	81
Consultants and Hospitals ...	10	2	2	14
Family Doctors	6	25	—	31
Children's Officer	8	5	—	13
Probation Officer	2	4	—	6
Parents	3	5	—	8
Others	21	8	8	37
	176	91	11	278

Children suffering from Epilepsy

Few handicaps call for so much thought, patience and tact from teachers and school medical officers and co-operation from parents and family doctors, as epilepsy, where a child's school career rises and falls with the regularity of his intake of anti-convulsants, and the problem becomes even more involved if behaviour or intelligence begin to deteriorate. Access to electroencephalography, and child guidance with regular contact between school and home by the educational psychologists attached to the child guidance clinics can do much to keep the epileptic child in the community. Three Cumberland children are at two residential special schools on account of epilepsy.

Maladjusted Pupils

There is one Cumberland pupil in a residential school for the maladjusted. The work of the Child Guidance Service is described on page 28.

Physically Handicapped Pupils

In addition to those 9 pupils in residential special schools as listed on page 39, a few examples of children remaining at home are of interest. A girl of eleven paralysed from the waist and totally blind after a tumour of the brain, arrested by radiotherapy, has been discharged from the only suitable special school catering for such multiple handicaps, and is fetched in her wheelchair several times a week in all weathers by her schoolmates who take her to join in singing and other classes at the local school. Inco-ordination of the hands has made Braille impossible, but an understanding home teacher is helping her to find compensating satisfaction in exploring the realms of music, of the mind and the imagination, and instead of being an invalid at home she is an active member of the school community.

A boy of eleven, paralysed after a spinal injury, remains in his home to which adaptations have been made for him and attends the nearby primary school where the personal interest of the headmaster is helping him to overcome not only the handicap of being confined to a wheelchair, but also the effects of having missed months of full-time education, and it is hoped that he will ultimately take the 11 plus examination as a late candidate.

Similar allowances for limitation of locomotion and for personal toilet requirements have in another primary school enabled a boy with a severe kidney condition and paralysis to increase his schooling from home tuition initially to part-time ordinary school for a period, and ultimately to a full day's curriculum, much to the satisfaction of his parents who, accepting the possibility of a sudden relapse in his condition, prefer that this should not happen while away at a special school outside the county.

Bronchiectasis, occurring in children whose parents resist the offer of residential schools, presents a challenge in collaboration if an alternative is to be found, and school medical officers and health visitors have an important part to play in impressing on pupils and parents the necessity to attend chest clinics regularly and carry out postural drainage and breathing and other exercises as conscientiously at home as at the clinics. Modern trends in the diagnosis and treatment of chest diseases in children and the role of physiotherapy were the subject of a lecture-demonstration given by one of the chest physicians and his physiotherapist at one of the regular meetings of school medical officers.

The after-effects of a head injury may, however well handled, produce handicaps in both the mental and intellectual fields as well as physical. In one quite severe illustrative case, co-ordination of the periodic reviews by the surgeon, school medical officer, and educational psychologist supported by a freely adapted syllabus of home tuition and by parental co-operation and intelligent handling of the highest order, has enabled the boy to resume part-time schooling a little over a year after the accident, with every prospect of carrying on the full carriculum in the following term.

Pupils with Speech Defects

There are no pupils in residential special schools on account of severe speech defect or lack of speech.

Delicate and Diabetic Pupils

There is little demand in Cumberland for places in residential " open-air " schools solely on the grounds of debility or malnutrition. Children in need of brief periods of convalescence, often from homes unable to cater for seaside holidays, benefit from the Sunshine Home at Allonby. While a period at a hospital special school may be desirable for handicaps such as asthma and bronchitis it should not be necessary to send a child away from a county such as this for " open-air " treatment if the school he would normally attend is a modern building which receives plenty of fresh air and sunlight, and where he makes full use of school milk and meals, and is allowed additional mid-day rest and if necessary is excused the more strenuous games.

The place of the diabetic child who is well stabilised and has a good home is also in the ordinary school as long as he continues to make progress and can satisfactorily administer his own injections, control his diet, and carry out his own tests for glycosuria. In such cases, of course, it is most important that both parents and teachers be made fully aware by the school medical officer of the various aspects and hazards of the way of life of the diabetic child.

Children Suffering from Cerebral Palsy

The number of children known to be suffering from cerebral palsy in Cumberland as at 31st December, 1958, is as follows:—

Number of spastic children of school age —	West Cumberland	43
	East Cumberland	18
	Total in Cumberland ...	61

These may be divided into those:—

(a) Attending ordinary school	33
(b) At Percy Hedley School for Spastics (Newcastle)	4
(c) At residential schools for the physically handicapped	1
(d) At residential schools for the educationally subnormal	1
(e) Attending occupation centre	3
(f) At Dovenby Hospital	4
(g) Having home tuition	4
(h) Not attending school, not having home tuition	11

3 awaiting admission to occupation centres
3 awaiting admission to Dovenby
1 awaiting 2 H.P. examination
2 awaiting final placement
2 awaiting final assessment

In addition:—

Number of children under school age but within the scope of the Education Act 1944 i.e. 2—5 years of age)

(a) Known spastics —	
West Cumberland	12
East Cumberland	9
Total in Cumberland	21
(b) Under observation or investigation —	
West Cumberland	5
East Cumberland	5
Total in Cumberland	10

The arrangements made by the County Health Authority for the diagnosis nd assessment of cerebral palsy remain as described in the previous Annual School ealth Reports for 1956 and 1957.

During the year the Cumberland Westmorland & Furness Spastics Society pened at Allonby, Solway Villa, a holiday home for cerebral palsied children. hose parents who visited the home were highly appreciative of it. Without a doubt his enterprise fulfils a long felt need among the parents.

Table Showing Handicapped Children in Special Schools

Name of School	Boys	Girls
BLIND		
Royal Normal College for the Blind, Shrewsbury	3	—
Royal Victoria School for the Blind, Newcastle	—	2
Total	3	2
PARTIALLY SIGHTED		
School for the Partially Sighted, Preston	5	—
Barclay School for Partially Sighted Girls, Berkshire	—	2
Total	5	2
DEAF		
Northern Counties School for the Deaf and Dumb, Newcastle	1	1
Royal College for the Deaf, Preston	2	—
Boston Spa Institute for the Deaf	1	3
Royal Residential School for the Deaf, Manchester	—	2
Burwood Park School, Walton on Thames	1	—
Total	5	6
PARTIALLY DEAF		
Northern Counties School for the Deaf and Dumb, Newcastle	—	1
Liverpool School for the Partially Deaf, Southport	1	1
Total	1	2
EDUCATIONALLY SUBNORMAL		
Salmon Cross School, Holmbury, St. Mary	—	1
St. Francis Residential School, Birmingham	1	2
Ian Tetley Memorial Hospital Home, Killinghall	1	—
Allerton Priory R.C. Special School	—	1
Ingwell Residential School, Moor Row	43	—
Higham Residential School, Cockermouth	—	30
Total	45	34

Name of School	Boys	Girls
EPILEPTIC		
Sedgewick House School, Kendal	2	—
Colthurst House School, Warford, Cheshire	1	—
Total	3	—
MALADJUSTED		
Chaigeley School for Maladjusted Boys	1	—
Total	1	—
PHYSICALLY HANDICAPPED		
Hesley Hall School for Physically Handicapped, Doncaster ...	1	—
Heritage Craft School for Physically Handicapped, Chailey ...	—	1
Percy Hedley School for Spastic Children, Newcastle	2	2
H. K. Campbell School, Carlisle (Day School)	1	—
Lorton Hall	—	1
W. J. Sanderson Hospital, Gosforth	1	—
Total	5	4
DELICATE		
Children's Convalescent Home, West Kirby	1	1
HOSPITAL SPECIAL SCHOOLS		
Stanington Children's Hospital School, Near Morpeth ...	3	—

Dental Service

The Principal Dental Officer makes the following comments on the dental service for 1958:—

" With still another year's extension granted to Mr. Lamond, the staff of dental officers has remained as before — one principal and eight officers (these figures do not take into consideration staff requirements for the maternity and child welfare service, which absorbs a little over one half of one officer) — giving a ratio of one dentist to 4,000 children, which compares favourably with the all-over picture of the school dental service which has a ratio of one to 6,682. In addition there is the prospect of another officer joining the staff early in 1959, so that at the moment the position is fairly well in hand. There is, however, no room for complacency as it is unlikely that Mr. Lamond will remain beyond 1960 in spite of his still youthful appearance and outlook. In these days when a single application for an advertised post causes quite a stir it is interesting to remember the pre-war days when short lists were drawn up of selected candidates who were duly interviewed and one chosen. It is feared that it will be a long time before that state of affairs returns. For the present local education authorities appear to be competing with one another as to which can offer the greatest inducements so as to attract staff.

"Practically all the orthodontic work has been undertaken by the Regional Hospital Board consultant, Mr. Roberts, and it is only right to mention the excellent work that is being done by him as well as the large number of cases that are being dealt with. During the year 382 cases were referred to him by the county staff, the few others were dealt with locally because of difficulty in attending Mr. Roberts' clinics.

"It is interesting to look back over the years of dental treatment of school children. Very little was done before the 1914-18 war, though a few authorities were operating schemes with full-time staff. After the war, however, matters developed rapidly and within a few years most of the country was more or less provided for, though the fully equipped fixed clinic was still a thing of the future, much of the work being carried out with elementary portable equipment using whatever accommodation was available in the various schools concerned. Primitive conditions resulted in primitive methods and finally primitive results, so that in the main " school dentistry " was not held in very high esteem. A remark by Sir Norman Bennett, Consulting Dental Surgeon to St. George's Hospital, in the " Health of the School Child " for 1922 is illuminating:—

> " The extraction of permanent teeth for children without an anaesthetic should be regarded as obsolete. As regards deciduous teeth, an anaesthetic other than a local application of one kind or

another is often unnecessary, but when the pain likely to be caused is at all comparable with what occurs with a permanent tooth an anaesthetic should be used."

"It is only when we consider the past we realise the progress that has been made, not only in the provision of specially built and well equipped clinics but in the greatly improved methods and enlarged scope of treatment available. This has naturally attracted the right type of dental officer, with the result that within staff limitations the service today is filling out in a very satisfactory manner its part in contributing to the health of the nation.

"Concurrently with the development of the school service has been the improvement in drugs and filling materials available, especially in relation to anaesthesia, both local and general. We have travelled a long way from the day when a solution of novacaine was prepared over a lamp from tablets, to the present time when a sterile cartridge filled with one of the latest preparations both isotonic and practically non-toxic is immediately available when required. On the other hand, the old general anaesthetic method of administering Nitrous Oxide alone, the "Gas and Grab" principle, has been replaced by the modern anaesthetic machine delivering a definite balanced mixture of gasses under immediate control of the anaesthetist, thus allowing any operation to be carried out without haste, in contrast to the former method where speed was the one essential for the operator, which did not always add to the subsequent comfort of the patient.

"During the same time the development of various antibiotics, penicillin especially, has done much to solve the problem of infection whether before or after operation, which, while greatly contributing to the patient's well being, has to a great extent solved one of the dentist's greatest headaches.

"The introduction of acrylic resins — plastics — has been an important step, though much remains to be done in the development of these materials, but even so they have as filling materials gone a long way to solve the difficulty of restoration of fractured incisors — always a major problem in school work. This has also been helped by the compactness and safety of the modern X-ray machine for investigation of root and bone conditions. Though still requiring caution in its use on account of radiation hazards, it is no longer a potential danger with an exposed lead carrying high voltage current. In fact a self contained unit in a convenient and easily portable case has been used even in private houses in Cumberland for many years, thus greatly helping in the diagnosis of many conditions.

"The foregoing advances are mainly the result of steady development, but on the equipment side the latest introduction is a complete innovation as far as operation is concerned, while it is completely revolutionary in effect. This is the Borden Airotor, a high speed air turbine drill for all cutting work on teeth. This instrument is so designed that it has only one moving part, the turbine, which driven by compressed air, attains speeds up to 250,000 revolutions per minute, at which speed vibration, one great trouble with the normal electric engine, is completely eliminated and cutting is so rapid and effortless that it has to be seen to be believed. There is no doubt that this is one of the major contributions to conservative dentistry and while two are being installed in the County Clinics it is hoped that in time it will be possible to install one in each main clinic.

"This brings up the important fact that in spite of its geographical difficulties and other local problems the county of Cumberland has kept well ahead in all these advances and, in addition, the County Council has assisted in obtaining a consultant in Oral Surgery and one in Orthodontics on the hospital staff of East and West Cumberland, with resulting benefit for the whole population. There are now 19 dental clinics functioning throughout the county, all with a good standard of equipment, so with very few exceptions children living anywhere from Millom to Alston are within comparatively easy reach of a clinic normally held once a week. This is good, but does not give any grounds for complacency, for as long as services are spread out too thinly each case requires more time to deal with and the simple filling becomes a compound one and so on. Without doubt the nearer it is possible to keep to the figure suggested by the Ministry of Education of one dentist to 3,000 children the more satisfactory the whole treatment scheme will be.

"One fact remains to be mentioned that is the important matter of dental clinic-school relationship. In Cumberland over the years this has been very good and it is greatly to the credit of the teaching staffs that they are almost invariably helpful in every possible way in spite of the nuisance value to them of the various interruptions of school routine consequent upon both inspection and treatment. Without this any scheme will fail. In a similar way full credit must be given to the Dental Officers and Attendants, upon whom the immediate responsibility falls of arranging matters as far as possible so as not to conflict with school interests and yet to do the necessary work.

"In my official capacity as Principal Dental Officer I wish to record my appreciation of the help we receive from the teaching staff and also to thank the dental staff for the way they maintain these good relations and for the happy atmosphere which normally marks the dental clinics."

PREVENTION OF ILLNESS AND PROMOTION OF HEALTH

Protection of School Children against Tuberculosis

Mass Miniature Radiography

Mass miniature radiography is offered to all school children (including those attending private schools) over the age of 13 years in the county. I show below the findings at mass radiography so far as the 2,257 school children involved are concerned, and separately the results of mass radiography in the children born 1944, i.e. those involved in the B.C.G. scheme.

Children X-rayed on miniature films	2,257
Children recalled for large film examination	56
Children recalled for clinical examination	13
Children found with active tuberculosis	—
Children found with inactive tuberculosis	2
Children found with bronchiectasis	1
Children found with abnormal cardiac conditions	2

Children in 1944 age group as shown on nominal rolls ...	3,509
Children in 1944 age group who had Mass Radiography reports	1,528
Consents given for B.C.G. vaccination	2,560
Children in 1944 age group with satisfactory Mass Radiography report	1,505
Children in 1944 age group with unsatisfactory Mass Radiography report and recalled for large films	23
Children in 1944 age group found to be satisfactory when recalled for large film	14

B.C.G. Vaccination

In 1958 explanatory letters were sent to the parents of 3,509 children (3,165), and the acceptance rate was 73% (73%) which, bearing in mind that some of the non-acceptors would have had B C.G. vaccination under the contact scheme, may be considered a reasonably satisfactory response, and I believe is rather higher than that found generally in the country. Tests were actually completed on 2,472 (2,276) children, which represents 70% (72%) of the school child population in respect of whom the offer was made. Of these 614 (697) gave a positive reaction, showing that they had at some time been exposed to tuberculous infection. The percentage positive was 24.8% (30.6%). Of the 1,843 (1,570) negative children 1,840 (1,566) were given B.C.G. Vaccination.

Note: Figures in parentheses refer to the year 1957.

The table below gives the figures for Mantoux testing of 13 year old school children since the scheme started in 1955.

DISTRICT	Children Born 1941 Tested in 1955 No. Tested	No. Positive	% Positive	Children Born 1942 Tested in 1956 No. Tested	No. Positive	% Positive	Children Born 1943 Tested in 1957 No. Tested	No. Positive	% Positive	Children Born 1944 Tested in 1958 No. Tested	No. Positive	% Positive
Alston	26	3	**11.5**	31	11	**35.5**	32	19	**59.4**	39	6	**15.4**
Border	222	40	**18.0**	236	68	**28.8**	230	49	**21.8**	267	38	**12.8**
Keswick	101	10	**9.9**	78	30	**38.5**	99	28	**28.3**	92	19	**20.7**
Penrith R.D.	60	9	**15.0**	58	13	**22.4**	62	10	**16.1**	66	16	**24.2**
Penrith U.D.	133	30	**22.6**	137	45	**32.8**	134	30	**22.4**	135	20	**14.8**
Wigton	224	62	**27.7**	231	55	**23.8**	283	69	**25.3**	288	52	**18.1**
Total East Cumberland	**766**	**154**	20.1	**771**	**222**	29.0	**840**	**205**	24.4	**887**	**151**	17.0
Cockermouth R.D.	45	14	**31.1**	75	28	**37.3**	60	18	**30.0**	14	3	**21.4**
Cockermouth U.D.	91	34	**37.4**	101	23	**22.7**	104	30	**28.8**	157	34	**21.7**
Ennerdale	209	81	**38.8**	242	101	**41.7**	311	114	**36.7**	286	101	**35.3**
Maryport	119	42	**35.3**	108	37	**34.3**	108	41	**38.0**	160	50	**31.3**
Millom	132	56	**42.4**	146	65	**44.5**	170	60	**35.3**	184	64	**34.8**
Whitehaven	414	145	**35.0**	315	149	**37.3**	325	111	**34.1**	384	129	**33.3**
Workington	414	141	**34.1**	384	130	**33.9**	358	118	**30.2**	400	82	**20.5**
Total West Cumberland	**1424**	**513**	36.0	**1371**	**533**	39.0	**1436**	**492**	34.3	**1585**	**463**	29.2
GRAND TOTAL	**2190**	**667**	30.4	**2142**	**755**	35.3	**2276**	**697**	30.6	**2472**	**614**	24.8

Medical Examination of Teachers

	Total	Category A1	A2	B1	B2	C
Entrants to Training Colleges Form 4 R.T.C.	77	49	27		1	
Entrants to employment as teachers by Cumberland Education Committee (Form 28 R.Q.)	40	27	12		1	
There were examined in addition —						
"Experienced" teachers from other authorities entering employment in Cumberland ...	78	72	4		2	
	195	148	43	—	4	—

A.1.—Those who are in good health and free from any physical defect.

A.2.—Those who are in good health but possess defects which are not likely to interfere with efficiency in teaching.

B.1.—Those who are in good health but suffer from physical defects (including disfigurement or deformity) which are likely to interfere, to some extent, with efficiency in teaching though they are not serious enough to make the candidate unfit for the teaching profession.

B.2.—Those who are temporarily in sub-normal health, but may, under treatment make a good recovery.

C.— Those whose condition is such as to make them unfit for the teaching profession.

Prevention of Diphtheria

The arrangements for diphtheria immunisation were rather curtailed during 1958. Pre-school children continue to be immunised at infant welfare centres or by general medical practitioners at their surgeries, usually between the ages of 9 months and 1 year. Normally a " booster " dose is given when the child enters school so that immunity is maintained, another at 9 years and another at 13 years, and those children not immunised before commencing school are given, subject to the parent's consent, a full course of injections on starting school.

As a result of the extended programme of vaccination against poliomyelitis, the number of school children who were immunised fell appreciably during 1958, only 140 children being immunised and 1,553 were given " booster " injections.

For the tenth year in succession no case of diphtheria was notified in Cumberland. In the circumstances described above, there is a very real danger that unless the rate of acceptance of diphtheria immunisation is increased, cases of diphtheria will occur again in Cumberland as has been the case recently in other parts of England. It is necessary to stress this because there is a risk that as propaganda is reduced owing to pressure of other work, a complacency may develop among parents who might think that there is no longer any need for them to trouble about diphtheria immunisation for their children.

Poliomyelitis Vaccination

The registration of eligible groups for vaccination against poliomyelitis was extended by Ministry of Health circular 20/58 to persons born in the years 1933-1942, i.e. 10 years beyond the existing upper age limit. This meant that additional school children, of whom the majority are the older children in grammar schools, became eligible for registration and subsequent vaccination. At the same time instructions were given regarding the administration of a third injection of poliomyelitis vaccine, it being proposed that the third injection should be offered not less than seven months after the second injection.

During 1958 more liberal supplies of vaccine arrived from the Ministry and it was possible to vaccinate with two injections the majority of those children whose parents had registered them. In addition to receiving British vaccine in rather limited quantities, large consignments of Salk vaccine which had been manufactured in Canada and the U.S.A. were made available. This vaccine had been subjected in this country to the same safety and potency tests as were applied to the British vaccine. Finally, there were released large consignments of this Salk vaccine which had been tested and licensed for use in the country of origin, but which had not been subjected to further tests in this country.

The following table illustrates the position, as far as school children were concerned, at the end of 1957:—

Year Born

	1943	1944	1945	1946	1947	1948	1949	1950	1951	1952	TOTAL
Received two injections ...					393	355	346	351	289	344	2,078
Received one injection ...					10	14	17	15	14	10	80
Awaiting vaccination ...	853	1,098	962	931	3,237	2,941	2,859	2,788	2,765	2,537	20,971
Total registered	853	1,098	962	931	3,640	3,310	3,222	3,154	3,068	2,891	23,129

During 1958 those children born in 1953 commenced school and so they are included in the next table. Children born in 1942 or sooner became eligible for vaccination, and they too are shown.

Year Born

	1942 or sooner	1943	1944	1945	1946	1947	1948	1949	1950	1951	1952	1953	TOTAL
Received three injections	—	—	1	2	—	255	241	244	242	210	214	204	1,613
Received two injections	619	1,993	2,619	2,297	2,774	3,298	3,021	2,905	2,875	2,815	2,743	2,499	30,458
Received one injection	107	50	34	19	24	21	20	19	19	23	36	34	406
Awaiting Vaccination ...	38	128	32	26	39	44	55	53	37	47	47	100	646
Total registered ...	764	2,171	2,686	2,344	2,837	3,618	3,337	3,221	3,173	3,095	3,040	2,837	33,123

All children attending independent and private schools in the county had similar facilities offered to them for registration and vaccination. Continued provision was also made for vaccination of children to be carried out by their general medical practitioners. The acceptance rate for the whole range shown is over 80%. The table shows the position as at 31st December, 1958, when only 646 school children were awaiting vaccination out of a total number registered of 33,123, whereas at 31st December, 1957, there were 20,971 school children awaiting vaccination from a total registration of 23,129.

Prevention of Infectious Diseases

Preventive inoculation has done much to reduce the incidence of infectious disease in school children and the child who enters school fully protected against smallpox, diphtheria, whooping cough and poliomyelitis, is indeed fortunate, particularly when at the age of 13 vaccination against tuberculosis is added. While the protection of larger numbers of pre-school children will be dependent on the untiring efforts of health visitors and doctors, there is still much to be done by teachers and health visitors through the medium of the health education syllabus in producing generations of future parents who have developed among other health habits the attitude that when it comes to inoculations their children too will "have everything that is going."

Games and play bring with them the numerous falls and scratches and the risk of tetanus, and the comparative rarity of the condition tends to mask its fatality. The advantages of active immunisation in childhood are obvious over the need for repeated injections of anti-tetanic serum at the doctor's surgery or casualty department, which may involve the loss of half a day's schooling or more.

In the meantime there still remain parents who refuse protection and there are diseases for which no effective vaccine is as yet developed, and we fall back on the old fashioned measures to control the spread of infectious disease. Early isolation is impossible where no sick-bay facilities exist, and a child must wait until afternoon for his parents to return from work. Inadequacies in ventilation, in toilet habits and personal hygiene in general are soon shown up in an outbreak in a school and many have still to learn the hard way that "coughs and sneezes spread 'FLU AND diseases". As to general resistance it is too early to judge whether over-indulgent "televiewing" habits will threaten the well-being that comes from abundant spontaneous play, physical exercise and ample sound sleep.

The supervision of contacts of infectious disease, now reduced to an absolute minimum since the publication of the Memorandum on the Closure of Schools and Exclusion from School on Account of Infectious Illness, issued jointly by the Ministry of Education and the Ministry of Health in 1956, commands, for all the more reason, implementation to the last letter of the law. Unless the recommended procedures are held to rigidly and consistently by parents, teachers and family doctors, this means of control becomes confused and farcical. To encourage such consistency the Appendix on exclusion periods has been circulated to all heads of schools and to general practitioners, and is reproduced as Appendix D, at the end of this report.

The value of notification of infectious diseases such as tuberculosis and food poisoning is obviously limited and prevention must be dependent upon initial and routine x-ray of all staff likely to come into contact with school children, and elimination from food handling of persons unwittingly carrying organisms of infectious disease, or continuing to handle food while a contact of a case of infectious disease at home. Notifications of scarlet fever can at best give a very incomplete picture of the movement and behaviour in our midst of the streptococcus, and while it remains unnecessary to notify cases of rheumatic fever and nephritis in children, any hopes of greatly reducing the lasting handicap which so often results from these diseases must be dependent on the co-operation of general practitioners and eradicating from households what has come to be called the "entrenched streptococcus".

Details of cases of infectious disease in children of school age are given in the table below:—

	Scarlet Fever	Whooping Cough	Ac. Polio Paralytic	Ac. Polio Non-Paralytic	Measles (Excluding Rubella)	Dipththeria	Dysentery	Meningococcal Infection	Ac. Pneumonia	Smallpox	Ac. Encephalitis Infective	Ac. Encephalitis Post-Infectious	Enteric or Typhoid Fever	Paratyphoid Fevers	Erisipelas	Food Poisoning	T.B. Respiratory	T.B. Meninges & C.N.S.	T.B. Other	TOTAL
Urban																				
Cockermouth ...	2	1	—	—	2	—	18	—	—	—	—	—	—	—	—	—	—	—	—	23
Keswick ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Maryport ...	17	—	—	—	4	—	1	—	—	—	—	—	—	—	—	—	—	—	—	22
Penrith ...	4	—	—	—	5	—	17	—	2	—	—	—	—	—	—	—	—	—	1	29
Whitehaven ...	18	—	—	1	136	—	—	—	1	—	—	—	—	—	—	—	—	—	1	157
Workington ...	6	4	—	—	8	—	5	—	2	—	—	—	—	—	—	—	4	1	—	30
Rural																				
Alston ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Border ...	4	—	—	—	2	—	4	—	—	—	—	—	—	—	—	—	2	—	—	12
Cockermouth ...	5	3	—	—	4	—	3	—	—	—	—	—	—	—	—	—	—	—	—	15
Ennerdale ...	14	3	—	—	15	—	—	—	1	—	—	—	—	—	—	—	2	—	—	35
Millom ...	3	1	—	—	4	—	2	—	—	—	—	—	—	—	—	1	2	—	—	13
Penrith ...	2	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3
Wigton ...	4	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	4
TOTAL ...	79	13	—	1	180	—	50	—	6	—	—	—	—	—	—	1	10	1	2	343

Tuberculosis

13 school children were notified as suffering from tuberculosis and 1 case (originally notified 5.9.49) was restored to the register as suffering from tuberculosis during 1958. Details are given in the table below.

Age Period	5-10 years		11-15 years		15 years and over		Total	
Sex	M.	F.	M.	F.	M.	F.	M.	F.
Pulmonary	3	3	1	1	1	1	5	5
Non-Pulmonary	2	1	—	—	—	1*	2	2
TOTAL	5	4	1	1	1	2	7	7

*Restored Case

School Premises

I referred last year to a schedule now in use by school medical officers based on the Standards for School Premises Regulations 1954. This has proved its worth as a guide to head teachers as well as to medical officers on the aspects of the school-child's environment on which the Ministry of Education consider a standard should be specified, as well as providing a concise and methodical channel for the transmission of information from the field to the central office.

It is obviously impossible to bring all schools up to the suggested standards in all respects in a short space of time, but this does not detract from the value of this method of inspection and reporting which serves to bring out certain deficiencies which can either be dealt with on the spot or included in minor building. The remedy is comparatively simple for defective lavatories, lack of hot water, soap and towels, and inadequate ventilation, while the penalty for false economy may well be a falling off in school attendance from coughs, colds, influenza and intestinal diseases.

The trend in medical examinations in the future may well be in favour of less frequent but more intensive and more selective examination of pupils. Even if pupils from some of the older urban schools come into clinics to be more fully examined, the need for an adequate medical suite in new secondary schools is if anything greater. Such an arrangement should cause less disruption and minimise time lost out of class by eliminating travelling, as well as providing a focal point for discussion between medical officer, teacher, nurse, parent and, where necessary, psychologist or other ancillary worker in the health and education field, for it is in combined casework of this kind that the school health service is at its best and in its correct sphere of influence.

School Meals

The Director of Education, Mr. G. S. Bessey, has supplied the following report on the School Meals Service, along with the note on Milk in Schools which follows:—

"During the year 1958 a hot mid-day meal was again available to all children of school age attending each of the 281 nursery, primary and secondary schools maintained by the Authority, who wished to take advantage of this provision. In fact, children took dinners at all these schools with the exception of Beckermet C. of E. where there was no demand for this service.

"Between September 1955 and October 1957, there was a fall of 4% in the numbers of children taking meals, in the main, owing to two increases in the price of dinners which became effective on 1st September, 1956, and 1st April, 1957 respectively. I am, however, pleased to be able to report that this downward trend did not continue during 1958. On a check day in October, 1957, 20,498 children, representing 60.15% of the number in attendance, took a school dinner but by September, 1958, the figure had risen to 61.09% and consumption showed an increase of some 660 dinners daily. The total number of dinners served on a check day in September, 1958, was 21,157.

"During the year under review, new secondary schools at Cockermouth and Cleator Moor and a new primary school to replace Houghton C. of E. School, each with appropriate facilities for the service of school meals, were completed and taken into use.

"The 400 meals kitchen, which forms part of the new Cockermouth Derwent School, opened on 1st September, 1958. Since the children who formerly attended Cockermouth All Saints' Secondary School were absorbed into Derwent School, the numbers of pupils using the dining centre in Cockermouth All Saints' Parish Rooms (which was formerly shared by Cockermouth All Saints' Secondary and Infants Schools) fell to such a level that it was uneconomic to continue to rent these premises. Consequently, they closed at the end of the Autumn Term, 1958, and as from the beginning of the Spring Term, 1959, children attending Cockermouth All Saints' Infants' School will dine in the school premises.

"Cleator Moor Ehenside School includes a 350 meals kitchen and this began to produce dinners when the school opened on 20th October, 1958.

"The new Houghton C. of E. School opened on 21st April, 1958, and a servery, to cater for approximately 100 meals daily, was taken into use on that date. This provision is a great improvement on the meals facilities in the old school.

"Work on the erection of a new 250 meals kitchen and dining room for Keswick School, and improvements to the Hogarth School Room in Rosemary Lane, Whitehaven, so as to fit it for re-occupation as a dining centre by children attending

Whitehaven, Crosthwaite Memorial C. of E. School, were completed during the year. The kitchen and dining room at Keswick School have already been taken into use and pupils attending Whitehaven, Crosthwaite School, who have, as a temporary expedient, been dining on the school premises, will move into their renovated dining centre on 6th January, 1959. Work also began during the year on a dual-purpose 200 meals dining room/classroom and scullery at Workington Newlands School.

"Children attending Kirkbride School have enjoyed improved dining conditions since 9th June, 1958, on which date a new dining centre in the Recreation Room was taken into use in place of the former one in the Church Institute. Not only are the new premises more roomy and much nearer to the school, but it has also been possible to include a properly-equipped scullery in them.

"During the early part of the year it became apparent that the number on roll at St. Bees Village School would increase considerably at the beginning of the Autumn Term and that the room used for dining would then be required as classroom space. Steps were, therefore, taken to rent the St. Bees Scouts Hut for alternative dining accommodation and these premises were taken into use for this purpose on 1st September, 1958.

"Towards the end of the year an opportunity to improve dining conditions for children in attendance at Millom St. James' R.C. School presented itself in the shape of an offer by the R.C. Church Authorities to allow the Education Committee to rent part of the St. James' Church Institute premises as dining and scullery accommodation. This offer was accepted gratefully since, hitherto, meals had been served in a classroom which was in use for normal teaching purposes. The new accommodation will be occupied on 5th January, 1959.

"Since conditions of hygiene in the Lindow Hall, Bowness-on-Solway, which for many years had served as a kitchen and dining room for Bowness School, fell short of the standards required by the Food Hygiene Regulations, it was decided to cease cooking dinners there after the end of the Summer Term, 1958, and to use the premises as a dining centre only from the beginning of the Autumn Term, 1958, dinners being sent in from Wigton Central Kitchen.

"During the year under review further improvements have been carried out at a number of sub-standard meals premises so as to bring conditions of hygiene there up to the level required to satisfy the Food Hygiene Regulations. However, more work still remains to be done in this connection and outstanding defects will be dealt with as quickly as possible.

"With the approval of the Ministry of Education, the kitchen at Workington Secondary Technical School ceased to be administered by the school meals service and passed under the control of the Governors of Workington College of Further Education on 1st September, 1958.

Milk in Schools

"A check taken for the Ministry of Education on a day in September, 1958, showed that, of the 36,539 day pupils present at the 281 nursery, primary and secondary schools maintained by the Authority, 26,857 were taking milk. These figures indicate that 73.5% of Cumberland children were drinking milk in schools at the time of the check as compared with last year's figure of 71.7%.

"The following table shows the percentage of different types of milk being supplied to maintained day schools at the end of 1958, the corresponding figures for 1957 being shown in brackets:—

Pasteurised	55 (60)
Tuberculin tested	44 (38)
Attested	1 (2)"

Physical Education

I am indebted to the Chief Organisers of Physical Education, Miss Kathleen Sutton and Mr. Lionel Heyworth, for the following report:—

"Physical education contributes in no small measure to a liberal education, for the life of the school child is largely influenced by the activities in which he participates, not only in school itself but also in the many fields of sports, clubs and hobbies which are associated directly or indirectly with the school curriculum. The steady advance of the Committee's building programme, with its well-equipped secondary schools; the natural facilities of the countryside, with their opportunities for walking, camping, climbing, cycling and canoeing, and the provision of playing fields and hard court areas, with their offer of variety in games and athletics have presented Cumberland teachers with a breadth of approach to secondary physical education which they have been eager to grasp. Through this broad approach at secondary level comes the opportunity of selecting and developing activities according to personal inclination and special bent in preparation for recreation and other physical activity in post-school years, in the youth club or the further education class, on the fellside or the sports ground.

"The foundations for such development are laid in the primary schools where the child gains confidence and skill in exploration and basic technique. Later he has the opportunity to mature in the field of further education.

"This year particularly has seen a recruitment to specialist posts of teachers trained at advanced level in the Training College and in the College of Physical Education, and the return of those who have taken advantage of a year's supplementary course.

"In order to assist teachers in method and approach at all levels of education, courses and demonstrations have been arranged and taken by the physical education organisers with the valuable help of adult organisations where highly qualified coaching was required, in association football, camping, canoeing, rock-climbing, personal health and appearance, traditional dance, basic movement and dance, netball, hockey, rugby football, sailing and tennis. In the major games courses teachers had the opportunity of qualifying for the preliminary coaching awards.

"The general standard of performance in sport is invariably raised if pupils of merit are given special attention. With this principle in mind, selected pupils from secondary schools have been coached in tennis at Workington during the autumn term and used for demonstration at teaching classes. The Cumberland Schools' Football Association, in association football, and the Cumberland and Westmorland Schools' Rugby Union, in rugby, organised residential courses for senior boys at Keswick where coaching methods were demonstrated to groups of teachers during the spring term, while the Cumberland Schools' Cricket Association held its annual coaching course at Workington during the Easter Holiday. Other schools' coaching courses in football, rugby and cricket have been arranged on a district basis by voluntary organisations throughout the county. In the autumn term the Cumberland Netball Association and the Cumberland Women's Hockey Association arranged coaching courses at Keswick and Whitehaven. Coaching has also been undertaken in schools by professional coaches of the Football Association, the County Cricket Club and the Lawn Tennis Association.

"Through the work of voluntary associations the progressive games and athletic training has been applied with considerable credit at secondary level by Cumberland teachers outside school hours, in the evenings, at week-ends and during school holidays. From the friendly school game to the county fixture, from the local tournament to the county rally, from the county trial to youth and adult teams, from the school sports to the national athletic championships, the very creditable efforts and achievements of Cumberland school children and young people have reflected the zeal, perseverance and sacrifice of teachers. Voluntary associations and Cumberland children look towards those young teachers who have recently entered the profession and who are able to impart to boys and girls by practical example and guidance on the games field, in the swimming bath, on the lake and in the hills, the knowledge which they themselves have obtained under training. This is work in which pleasure and reward multiply with the doing."

Health Education

I have referred in the Preface to the importance of health education in schools. In 1956 the Ministry of Education issued a pamphlet containing suggestions for the consideration of teachers and others concerned in the health and education of children and young people. We in Cumberland after careful study of this pamphlet are now considering the methods most suited to our own community.

The Superintendent Nursing Officer, Miss Mansbridge, reports on the work undertaken by the school nursing service in health education during the year:—

"A certain amount of formal education is given by health visitors during school hours at fortnightly periods during the pre-nursing courses, and at one girls' secondary school a period is allocated fortnightly for the teaching of mothercraft. In addition, a number of other schools set aside periods for informal discussion groups illustrated by film strips, flannelgraphs, and the usual health education media. Subjects taught to junior girls in their last term and senior girls included personal hygiene, dental care, nutrition, good grooming and care of the feet. Formal health education is also incorporated by teachers into the physical education and domestic science syllabus.

"Until more time can be given by health visitors and more school periods allocated for this purpose the bulk of health education is of the 'incidental' type and consists essentially in personal advice from the health visitor to an individual child or small groups of children, either during the routine health inspections which are carried out once a term at each school or when the child is seen individually at the clinic or in his own home, as for example on the numerous follow-up home visits which a health visitor has to undertake to ensure that the treatment recommended for defects discovered at medical inspection is being carried out. It is under these latter circumstances that health visitors have taken every opportunity to bring home the dangers of heavy cigarette smoking.

"During the 'Guard that Fire' campaign in November, health visitors put on a display in each of the clinics, and posters were displayed in prominent positions in schools and a great deal of publicity material was distributed not only to schools but to homes in which there were young children."

The nationwide 'Guard that Fire' campaign in November served to remind us of the indispensable part to be played by adequate health education of children while at school in the extent and risks of burning accidents. The problem of reduction of these accidents has many features in common with the reduction of road accidents in which teaching staff, the County Road Safety Officer, the police, and local accident prevention committees are making headway. Arising from the campaign a number of local home safety committees are being either revived or newly formed along the lines of the Campaign Guide and it is anticipated that at meetings of these committees local teachers and health visitors will be present either as members or in an advisory capacity. To mark this revival of activity, displays were put on at school clinics and suitable schools and county libraries, as well as other public places, and campaign material for distribution was made available on request to heads of schools.

Accidents occurring in overcrowded homes and among problem families may well be a manifestation of neglect of the child in his own home and as such lend themselves admirably to discussion at local committees set up primarily for the prevention of break-up of families, provided always that mutual representation on these and home safety committees ensures a co-ordination of efforts.

Children can be taught to use domestic irons and volatile cleaning agents with respect and made to realise the results of carelessness in handling matches, fires, petrol and paraffin, in undressing in front of unguarded fires, and in reaching over a fire to see in a mirror or take an object off the mantelshelf.

Parents can play their part by having efficient fireguards fitted and realising the law on the subject which deserves quoting in its entirety:—

"If any person who has attained the age of 16 years, having the custody, charge or care of any child under the age of 12 years, allows the child to be in any room containing an open firegrate or any heating appliance liable to cause injury to a person by contact therewith not sufficiently protected to guard against the risk of his being burned or scalded without taking reasonable precautions against that risk, and by reason thereof the child is killed or suffers serious injury, he shall on summary conviction be liable to a fine not exceeding £10".

Dr. P. T. Regester has taken great interest in Health Education in Schools and from his report I quote some sections which seem relevant to the new light in which some of us in the school health service are looking at this subject:—

"The traditional school medical inspection is now becoming subject to scrutiny. One thing is certain—that the florid disease, the poverty, the malnutrition, the infestations of the past are no longer rife; they are, one hopes, banished for good. More and more one finds that the minor defects and departures from the norm—conditions like knock-knees, flat feet, 'the adenoidal facies', enlarged tonsils, the innocuous cardiac murmurs (all susceptible of everlasting reinspection)—deserve less and less of our attention. In an age which has been called the age of anxiety and compulsion, the maladjusted and insecure child stands awkwardly before us, the frantic nail-biter, the shame-faced bed-wetter. (In his later years to become perhaps, the furious smoker, and finally the chain-smoker? Possibly indeed the aetiology of the latter is not dissimilar). The time allotted for each medical inspection is never enough for this sort of diagnosis or the investigation of this sort of problem. These cases require the privacy of the clinic (or better the school health centre) and need to be **selectively examined** perhaps once a term or even more frequently. Almost one might say, we are diagnosing not disease but unhappiness. In a similar fashion further selectivity is required for those children who seem not to be making the most of their educational chances, whose emotional and mental states and whose social habits show retardation or retrogression. Here in collaboration with the educational psychologist, the problem is of aptitudes, attitudes, and mental, emotional and social development.

"Ordinary routine medical inspections cannot be considered as redundant or supererogatory. The great drawback with the examinations is that they constitute an artificial situation conducted in surroundings which are either cramped and lacking in privacy, or are barn-like and severe. No adequate rapport can be readily established and who can wonder that the results are sometimes sterile. It is much more fruitful to firstly see the pupils at their desks in the classrooms and secondly, to conduct a group medical examination taking the senior (11+) pupils in batches and, while dressing, undressing and medical inspection is taking place, to stimulate among the group a running conversation (including in this the modern substitute for conversation, back-chat). It is surprising how soon contact may be made and how readily the slow, isolated, the unhappy, the victimised child comes to one's notice. It is surprising, too, how well the pupils listen to a few words of health education brightly delivered in such a situation; for it is no longer one child placed in the unnatural posture of the medical examinee, it is now a social occasion, having the atmosphere of the changing-room of the gym. It is from such group examinations the selective examinations can be based. In the age groups under 11 years the proportion of mothers attendings is higher, progressing inversely with age until at 5 years it becomes exceptional—and often in itself indicative — for mothers not to attend. Here too the situation takes on artificiality—we do not see a mother anxious with a sick child, but a mother summarily asked to present herself at such a time. It is very much up to the school medical officer to make it something more. For in this situation the mothers also come in for a certain amount of social diagnosis! Is mother an emotional blanket suffocating the child, or is she the refrigerative type freezing affection from the child's nature? In this situation too the mothers are also in a receptive state for a certain amount of teaching, for this is the climate and this is the soil for health education. The justification for group medical examinations is that the inspections provide an excuse for social examination, offering as it does a standard social situation.

"In the medical press, the daily papers and the periodicals there has been debate about the effect of television on the child. Little has emerged of a positive nature. Medically there has been some concern over the possible effects on the child's visual acuity, but no symptom or syndrome is attributable. Probably the danger is not to the vision of the eye, but rather to that imaginative vision that gives 'the bread and the wine to the soul'. However even though television seems exonerated from the causation of eye defect, it must always be remembered that viewing too long may aggravate existing eye disease.

"A recent survey published by the Nuffield Foundation (Television and the Child) is worth reading by parents. One thing clearly emerges from it; this is that T.V. is a leveller; it tends to make the dull child **appear** brighter and the bright child duller. It also appears from this report that the children who become most persistently riveted to the machine are the emotionally disturbed, lonely, insecure children. It draws children away from pastimes and the reading of books but the brighter child very soon returns to its former reading habits when the novelty has ceased to attract. Perhaps the thing which worries teachers most has been the effect of T.V. on bed-time. Certainly more school doctors question children who are dull or listless or drowsy a little more closely about bed-time now that 'telly' is epidemic, and often he finds that bed-time is deferred on account of children watching the so-called adult programmes. The report substantiates this only in part, finding that the mean bed-time (for children between ten and eleven it was 8-45 p.m., between thirteen and fourteen 9-45) was advanced twenty minutes at the most. In passing it might be added that all of these bed-times are rather later than one would have thought desirable. Finally, the survey seems to indicate that many of the ills attributed to the machine are merely the predispositions and attitudes of the sort of people who acquire sets.

"School for most children is their only experience of a social group outside the family, and school life is a test of their social resilience and personal adaptability. On entry, as teachers and medical officers know, children take a widely varying time 'to settle' and there is no rushing the process. A frequent change of school puts additional strain on the sensitive child, both emotionally and socially. But at no period is the testing more searching than as they relinquish or prepare to relinquish the word of books and learning—some of them, alas, for ever—and face the disturbing and disturbed prospect of the wide world of adulthood. Though it is not possible here to enquire into the psychological states of adolescence, it is of interest to consider some aspects of 'the growing-up stage' as it affects health.

"One of the complicating factors about health education in the direction of the cigarette-cancer relationship is that the 'reasons' or 'incentives' to smoke are so numerous. In adolescence the cigarette is taken as an index to manhood, and a badge of entry into a manly group engaged in similar incendiarism. Solitary smoking is not I think the norm. In 2 secondary schools, 32% of male school-leavers showed some nicotine staining on their fingers. Their attitude to the cigarette-cancer relationship can only be described as one of levity. Disease and death seem very distant when one is ebullient with life. And of course one must not forget that the really important thing is that they relinquish the smoking habit—not that they believe or feel deeply about the cigarette-cancer relationship. To achieve this it is much more realistic to appeal to things which arouse their concern, however unimportant and superficial these may seem to older persons. In the case of boys such things as physical fitness, plus a little derision of the idea that the growing male needs a substitute 'dummy', plus disbelief that intelligent blokes like themselves would be mugs enough not to appreciate how relatively little one gets for one's money in a packet of 20, as against the new neck-tie, the guitar, the long-player, etc. The girls being much more mature than the boys readily appreciate how incongruous it is to spend money and time on make-up, home perms and elegant clothes, only to spoil the glamorous effect completely and utterly by sticking into their mouths a lolling cigarette and retaining it there by rather half-witted grimacings.

"Lastly one appeals to them not to repeat the mistakes of their parents, grandparents and distant ancestors who unhappily failed to heed the warnings of that hoary health educationalist James I, who in 1604 in his 'Counterblast to Tobacco' said:—

> 'Have you not reason then to be ashamed and to forbeare this filthie noveltie . . . . Customs lothsome to the Eye, hateful to the Nose, harmful to the Braine, dangerous to the Lungs, neerest resembling the horrible Stigian smoke of the Pit that is bottomlesse.'

"The number of girls using facial make-up is, of course, not easily determined from inspections at school, although sometimes soap, if applied, is not applied with sufficient vigour to delete the glamorous pigments. In fact there is a good case to be made out for instruction being given not only on the application of cosmetics, but also on their proper removal. Young girls have a tendency to plaster on additional layers to the detriment of the health and texture of the skin. Some 9% of 14-year old girls in one school had some trace of varnish on the finger nails and several with it on toe-nails also. In all cases the cosmetic was the property of the mother or an elder sister.

"One disturbing feature was the number of youngsters who needed to wear spectacles but steadfastly refused to do so. In general one notices this tendency beginning at 9 or 10 years, but the reason then seems to be the restriction that is placed on activity by the wearing of them. In the early adolescent group it is appearance and the desire to conform with other children which vitiates against their use. Children who do wear spectacles generally have frames bought privately and not obtained through the School Health or National Health Service.

"In one group of school leavers it was found that 39% of boys and 46% of girls had some tendency to flat-foot though most needed no treatment. In the same group, hallux valgus was present in some 8%. Boys of this age wear heavy (in some cases too heavy) footwear, not infrequently with the heels worn down farther than should be. In girls, on the other hand, the feet were covered sometimes with the flimsiest of shoes or with slippers. Ballerina type of footwear continues to be common. Any advice given as to suitable footwear as against the fashionable, seems best put over if one points out that a well proportioned shoe has by its nature a good appearance even though it lacks glamorous appeal.

"Nail biting varies from school to school, but seems more common than one would expect in this age group. In one set of 14-year old girls, about three-quarters had the habit.

"Of recent years the minds of the middle aged have been devoted to considering how the young teen-ager thinks, feels and acts. The attitudes seem to be crystallised into three viewpoints—the idiosyncratic regarding the young person as a sort of extravagantly garbed zani of the palais; the sentimental as 'Little Men' and 'Little Women'—appearing to perpetuate the mediaeval heresy of child psychology that the child was a man in miniature; and lastly, the moralistic view looking upon them as a primitive and violent breed 'beyond the law'. To get to the social roots of the problems of the teen-age—the adolescent sub-culture, the hooliganism, the crime—there is a need to study them in their final school years much more closely than has been done in the past. Teachers and medical officers could contribute much to their problems and **the** problem. The medico-social study of school-leavers and the adolescent have hardly been touched on. For adolescence is the mind and the body in bewildering transition, beginning to feel the full force of the sexual taboos and cultural fiats of our society".

APPENDIX A

MEDICAL INSPECTION AND TREATMENT

RETURN FOR THE YEAR ENDED 31st DECEMBER, 1958

Part I—Medical Inspection of Pupils attending Maintained and Assisted Primary and Secondary Schools (including Nursery and Special Schools)

Table A.—Periodic Medical Inspections

Age Groups Inspected (By year of birth)	No. of Pupils Inspected	Physical Condition of Pupils Inspected			
		SATISFACTORY		UNSATISFACTORY	
		No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)
1954 and later	100	97	99%	3	1%
1953	1,936	1,921		15	
1952	1,543	1,526		17	
1951	202	195		7	
1950	86	83		3	
1949	57	56		1	
1948	3,538	3,504	99.04%	34	0.96%
1947	262	259		3	
1946	99	97		2	
1945	79	79		—	
1944	2,800	2,788	99.57%	12	0.43%
1943 and earlier	185	185		—	
TOTAL	10,887	10,790	99.11%	97	0.89%

Table B—Pupils found to require Treatment at Periodic Medical Inspections

(excluding Dental Diseases and Infestation with Vermin)

Age Groups Inspected (By year of Birth)	For defective vision (excluding squint)	For any of the other conditions recorded in Part 11	Total individual pupils
(1)	(2)	(3)	(4)
1954 and later	2	10	12
1953	19	210	219
1952	18	211	222
1951	2	24	25
1950	4	12	14
1949	4	7	11
1948	154	256	390
1947	25	19	39
1946	8	4	10
1945	8	6	12
1944	168	154	306
1943 and earlier	21	9	26
TOTAL	433	922	1,286

Table C.—Other Inspectons

Number of Special Inspections	6,116
Number of Re-inspections	9,559
Total	15,675

Table D.—Infestation with Vermin

(a)	Total number of individual examinations of pupils in schools by school nurses or other authorised persons	72,691
(b)	Total number of individual pupils found to be infested	1,010
(c)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	Nil
(d)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	Nil

Part II—Defects found by Medical Inspection during the Year

Table A.—Periodic Inspections

Defect Code No.	Defect or Disease	PERIODIC INSPECTIONS Entrants (T)	(O)	Leavers (T)	(O)	Others (T)	(O)	Total (T)	(O)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
4	Skin	21	73	29	62	26	80	76	215
5	Eyes —								
	a. Vision ...	39	148	168	407	226	607	433	1,162
	b. Squint ...	30	78	9	46	18	92	57	216
	c. Other ...	22	27	12	19	35	34	69	80
6	Ears —								
	a. Hearing ...	14	70	5	39	17	49	36	158
	b. Otitis Media	5	62	4	12	9	36	18	110
	c. Other ...	14	20	6	9	5	25	25	54
7	Nose and Throat	123	504	7	64	35	240	165	808
8	Speech	33	85	4	13	13	42	50	140
9	Lymphatic Glands	7	119	1	6	5	43	13	168
10	Heart	—	32	1	24	5	31	6	87
11	Lungs	33	215	12	67	21	164	66	446
12	Developmental —								
	a. Hernia ...	5	24	1	—	3	8	9	32
	b. Other ...	4	56	4	14	6	179	14	249
13	Orthopaedic —								
	a. Posture ...	4	8	8	12	5	29	17	49
	b. Feet ...	48	91	10	33	34	73	92	197
	c. Other ...	48	200	19	68	33	97	100	365
14	Nervous System—								
	a. Epilepsy ...	—	7	2	8	—	10	2	25
	b. Other ...	7	15	1	3	8	13	16	31
15	Psychological —								
	a. Development	4	13	2	45	20	89	26	147
	b. Stability ...	4	16	—	15	4	37	8	68
16	Abdomen ...	2	30	1	14	5	32	8	76
17	Other	46	70	24	35	59	76	129	181

Table B.—Special Inspections

Defect Code No.	Defect or Disease	SPECIAL INSPECTIONS Pupils requiring Treatment	Pupils requiring Observation
(1)	(2)	(3)	(4)
4	Skin	525	31
5	Eyes—a. Vision ...	357	481
	b. Squint ...	30	19
	c. Other ...	198	29.
6	Ears—a. Hearing ...	70	52
	b. Otitis Media	22	20
	c. Other ...	38	4
7	Nose and Throat ...	145	112
8	Speech	48	34
9	Lymphatic Glands ...	7	15
10	Heart	3	9
11	Lungs	48	56
12	Developmental —		
	a. Hernia ...	—	2
	b. Other ...	—	7
13	Orthopaedic —		
	a. Posture ...	2	4
	b. Feet	61	13
	c. Other ...	42	31
14	Nervous System —		
	a. Epilepsy ...	1	12
	b. Other ...	11	9
15	Psychological —		
	a. Development	26	49
	b. Stability ...	18	41
16	Abdomen	27	28
17	Other	910	72

Part III—Treatment of Pupils Attending Maintained and Assisted Primary and Secondary Schools (Including Nursery and Special Schools)

Table A.—Eye Diseases, Defective Vision and Squint

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	216
Errors of refraction (including squint)	2,561
Total	2,577
Number of pupils for whom spectacles were prescribed	1,870

Table B.—Diseases and Defects of Ear, Nose and Throat

	Number of cases known to have been dealt with
Received operative treatment —	
(a) for diseases of the ear	3
(b) for adenoids and chronic tonsillitis	215
(c) for other nose and throat conditions	70
Received other forms of treatment	124
Total	412
Total number of pupils in schools who are known to have been provided with hearing aids—	
(a) in 1958	10
(b) in previous years	52

Table C.—Orthopaedic and Postural Defects

	Number of cases known to have been treated
(a) Pupils treated at clinics or out-patients departments	1,209
(b) Pupils treated at school for postural defects	—
Total	1,209

Table D.—Diseases of the Skin

(excluding uncleanliness, for which see Table D. of Part I)

	Number of cases known to have been treated
Ringworm—(a) Scalp	1
(b) Body	6
Scabies	5
Impetigo	106
Other skin diseases	483
Total	601

Table E.—Child Guidance Treatment

	Number of cases known to have been treated
Pupils treated at Child Guidance Clinics	286

Table F.—Speech Therapy

	Number of cases known to have been treated
Pupils treated by speech therapists	282

Table G.—Other Treatment Given

	Number of cases known to have been dealt with
(a) Pupils with minor ailments	1,039
(b) Pupils who received convalescent treatment under School Health Service arrangements	102
(c) Pupils who received B.C.G. vaccination	1,840

Part IV.—Dental Inspection and Treatment carried out by the Authority

(1) Number of pupils inspected by the Authority's Dental Officers:—			
(a) At Periodic Inspections	26,783		
(b) As Specials	786		
		Total (1)	27,569
(2) Number found to require treatment			17,558
(3) Number offered treatment			12,069
(4) Number actually treated			10,640
(5) Number of attendances made by pupils for treatment including those recorded at 11(*h*)			20,804
(6) Half days devoted to:—			
(a) Periodic (School) Inspection	252		
(b) Treatment	2,352		
		Total (6)	2,604
(7) Fillings:—			
(a) Permanent Teeth	8,319		
(b) Temporary Teeth	1,143		
		Total (7)	9,462
(8) Number of Teeth filled:—			
(a) Permanent Teeth	7,807		
(b) Temporary Teeth	1,035		
		Total (8)	8,842
(9) Extractions:—			
(a) Permanent Teeth	5,806		
(b) Temporary Teeth	10,874		
		Total (9)	16,680
(10) Administration of general anaesthetics for extraction			3,188

(11) Orthodontics:—

(a) Cases commenced during the year	13
(b) Cases carried forward from previous year	103
(c) Cases completed during the year	8
(d) Cases discontinued during the year	*188
(e) Pupils treated with appliances	13
(f) Removable appliances fitted	14
(g) Fixed appliances fitted	—
(h) Total attendances	153

* Mostly transferred to Regional Hospital Board orthodontist.

(12) Number of pupils supplied with artificial teeth ... 267

(13) Other operations:—

(a) Permanent teeth	4,787		
(b) Temporary teeth	485		
		Total (13)	5,272

APPENDIX B.

HANDICAPPED PUPILS REQUIRING EDUCATION AT SPECIAL SCHOOLS APPROVED UNDER SECTION 9(5) OF THE EDUCATION ACT 1944 OR BOARDING IN BOARDING HOMES

During the Calendar year ended 31st December, 1958, how many handicapped pupils —	Blind	Partially Sighted	Deaf	Partially Deaf	Delicate	Physically handicapped	Educationally sub-normal	Mal-adjusted	Epil-eptic	Total
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
A. were *newly placed* in special schools or boarding homes?	—	3	1	2	1	3	20	—	1	31
B. were *newly assessed* as needing special educational treatment at special schools or in boarding homes?	—	—	—	3	—	3	50	1	2	59
On or about 31st January, 1959, how many handicapped pupils from the Authority's Area										
C. (i) were on the registers of special schools as										
(a) day pupils	—	—	—	—	—	1	—	—	—	1
(b) boarding pupils	4	8	10	5	2	7	78	1	3	118
(ii) were on the registers of independent schools under arrangements made by the Authority	—	—	—	—	—	1	1	—	—	2
(iii) were boarded in homes and not already included under (i) or (ii)	—	—	—	—	—	—	—	—	—	—
TOTAL C.	4	8	10	5	2	12	79	1	3	124
D. were being educated under arrangements made under Section 56 of the Education Act, 1944										
(i) in hospitals	—	—	—	—	1	—	—	—	—	1
(ii) in other groups (e.g. units for spastics, convalescent homes)	—	—	—	—	—	—	—	—	—	—
(iii) at home	1	—	—	—	1	13	1	—	1	17

APPENDIX B — *Continued*

During the Calendar year ended 31st December, 1958, how many handicapped pupils	Blind	Partially Sighted	Deaf	Partially Deaf	Delicate	Physically handicapped	Educationally sub-normal	Maladjusted	Epileptic	Total
E. were requiring places in special schools	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
(i) TOTAL (a) day	—	—	—	—	—	—	—	—	—	—
(b) boarding	3	3	—	1	1	9	111	4	4	136
Please state how many pupils are included in the totals above —										
(ii) who had not reached the age of 5:—										
(a) awaiting day places	—	—	—	—	—	—	—	—	—	—
(b) awaiting boarding places	2	1	—	—	—	—	—	—	—	3
(iii) who had reached the age of 5 but whose parents had refused consent to their admission to a special school										
(a) awaiting day places	—	—	—	—	—	—	—	—	—	—
(b) awaiting boarding places	—	2	—	—	—	1	48	—	1	52
F. were on the registers of hospital special schools	...	...	...	...	...	...	27			

G. During the *calendar* year ended 31st December, 1958, how many children were reported to the local health authority: —

(a) under Section 57(3) (excluding any returned under (b))	13
(b) under Section 57(3) relying on Section 57(4)	—
(c) under Section 57(5) of the Education Act, 1944	11

APPENDIX C.

SCHOOL HEALTH SERVICE CLINICS

AS AT 31.12.58

ALSTON:

Dental — 2nd and 4th Tuesday — all day.
School — Each Wednesday a.m.

ASPATRIA:

Dental — 1st, 3rd and 5th Mondays — all day.
School — Each Wednesday a.m. — Medical Officer attending on 2nd and 4th Wednesdays only.
Orthopaedic Aftercare — 2nd Friday p.m., 4th Friday a.m.
Speech Therapy — Each Wednesday a.m.

BRAMPTON:

Dental — Each Wednesday — all day.
School — Each Friday a.m. with Medical Officer attending 1st and 3rd Fridays only.

CARLISLE:

Dental — Daily — all day.
— At Eden School — as required.
School — 2nd and 4th Wednesdays a.m. with Medical Officer in attendance.
Eye Specialist — Each Monday and Thursday a.m.
Orthoptic — Each Monday, Tuesday — all day.
E.N.T. Specialist — Each Monday p.m.
Child Guidance — Alternate Thursdays, p.m.
Speech Therapy — Each Tuesday p.m., Thursday a.m.
Orthopaedic Aftercare — Each Tuesday — all day.
Orthopaedic Surgeon — 1st Monday every odd month p.m. and every 8th Wednesday a.m., 1st Monday every even month a.m.

CLEATOR MOOR:

Dental — Each Wednesday — all day.
School — Each Monday and Thursday a.m. with Medical Officer attending 1st and 3rd Thursdays only.
Orthopaedic Aftercare — 2nd and 4th Tuesdays a.m.
Speech Therapy — Each Friday a.m.

COCKERMOUTH:

Dental — Each Tuesday, Friday and occasional Thursday — all day.
School — Each Monday and Thursday a.m. with Medical Officer attending 2nd and 4th Mondays.
Eye Specialist — Each Tuesday a.m.
Orthopaedic Aftercare — 1st and 3rd Wednesdays — all day.

EGREMONT:

Dental — Each Monday — all day.
School — Each Thursday a.m. with Medical Officer attending 1st and 3rd Thursdays.
Speech Therapy — Each Wednesday p.m.
Orthopaedic Aftercare — 2nd and 4th Tuesday p.m.

FRIZINGTON:

Dental — Each Tuesday — all day.
School — Each Monday and Wednesday a.m. — Medical Officer attending 2nd and 4th Mondays.

KESWICK:

Dental — Each Friday — all day.
School — Each Thursday a.m.
Speech Therapy — Each Thursday p.m.
Orthopaedic Aftercare — 3rd Monday p.m.

LONGTOWN:

Dental — Each Friday — all day.

MARYPORT:

Dental — Each Monday, Wednesday and occasional Thursday — all day.
School — Each Tuesday and Friday a.m. with Medical Officer attending on 2nd and 4th Tuesdays.
Speech Therapy — Each Wednesday p m.
Orthopaedic Aftercare — 1st and 3rd Tuesdays — all day.
Child Guidance — Each Monday p.m.

MILLOM:

Dental — Each Thursday — all day, each 2nd and 4th Fridays — all day.
School — Each Tuesday a.m. and Friday p.m. with Medical Officer attending 1st and 3rd Tuesdays only.
Speech Therapy — Each Thursday — all day.
Child Guidance — Thursday p m. as required.
Orthopaedic Aftercare — 3rd Monday — all day.
Eye Specialist — Each 1st and 3rd Friday a.m.

PENRITH:

Dental — Each Monday, 1st and 3rd Tuesday and occasional Thursday all day.
School — Each Tuesday a.m. with Medical Officer attending 2nd and 4th Tuesdays only.
Speech Therapy — Each Tuesday a.m.
Orthopaedic Aftercare — 2nd and 4th Wednesday all day.
Orthopaedic Surgeon — 1st Monday every even month p.m.
Orthoptic — Each Wednesday, all day.

SILLOTH:

Dental — Each Thursday all day.

WHITEHAVEN (Sandhills Lane):

Dental — Daily all day. 2nd Clinic Tuesday — all day.
School — Daily a.m. with Medical Officer attending each Wednesday morning.
E.N.T. Specialist — Each Tuesday a.m.
Eye Specialist — Each Monday, Thursday and Friday a.m.
Speech Therapy — Each Tuesday all day.
Orthopaedic Aftercare — Each Thursday all day.
Orthopaedic Surgeon — 1st Friday every odd month a.m. 2nd Wednesday every even month a.m., every 8th Tuesday.

WHITEHAVEN (Woodhouse):

School — Each Monday, Wednesday and Friday a.m. with Medical Officer attending each Wednesday.

WHITEHAVEN (Mirehouse):

Dental — As required.
School — Tuesday and Friday a.m.
Speech Therapy — Friday p.m.

WHITEHAVEN (10 Scotch Street):

Child Guidance — Each Wednesday, all day.

WIGTON:

Dental — Tuesday, Wednesday and Thursday — all day.
School — Each Monday a.m. with Medical Officer attending 1st and 3rd Mondays.
Speech Therapy — Each Friday a.m.
Orthopaedic Aftercare — 3rd Friday a.m.

WORKINGTON (Stoneleigh):

Dental — Monday, Thursday all day.

WORKINGTON (Park Lane):

Dental — Tuesday, Wednesday, Friday all day.
School — Daily a.m. with Medical Officer attending each Tuesday a.m.
Speech Therapy — Each Monday all day.
Orthoptic — Each Thursday and Friday all day.
Orthopaedic Aftercare — Each Friday all day.
Orthopaedic Surgeon — 1st Friday every even month a.m., 2nd Thursday odd month a.m. Every 8th Tuesday a.m.

	Usual incubation period (days)	Interval between onset and appearance of rash (days)	PERIOD OF EXCLUSION	
			Patients	Contacts, i.e. the other members of the family or household living together as a family, that is, in one tenement.
SCARLET FEVER (and streptococcal sore throat)	2 — 5	1 — 2	7 days after discharge from hospital or from home isolation. (Unless "cold in the head," discharge from the nose or ear, sore throat, or septic spots be present).	Children — no exclusion. Persons engaged in the preparation or service of school meals to be excluded until Medical Officer of Health certifies that they may resume work. (See last part of paragraph 37).
DIPHTHERIA	2 — 5	—	Until pronounced by a medical practitioner to be fit and free from infection.	At least 7 days. Return to school should not be permitted until bacteriological examination has proved negative.
MEASLES	10 — 15	3 — 4	10 days after the appearance of the rash if child appears well.	Children under 5 years of age should be excluded for 14 days from the date of appearance of the rash in the last case in the house. Other contacts can attend school. Any contact suffering from a cough, cold, chill or red eyes should be immediately excluded. A child who is known with certainty to have had the disease need not be excluded.
GERMAN MEASLES	14 — 21	0 — 2	7 days from the appearance of the rash.	None.
WHOOPING COUGH	7 — 10	—	28 days from the beginning of the characteristic cough.	Children under 7 years of age should be excluded for 21 days from the date of onset of the disease in the last case in the house. A child who is known with certainty to have had the disease need not be excluded.
MUMPS	12 — 28	—	7 days from the subsidence of all swelling.	None.
CHICKEN POX	11 — 21	0 — 2	14 days from the date of appearance of the rash.	None.
POLIOMYELITIS ENCEPHALITIS MENIGOCOCCAL INFECTION	7 — 14 4 — 30 2 — 10	— —	(At least 6 weeks. (Will usually require a much longer (period for recovery.	At least 21 days.

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ASCERTAINMENT OF DEAFNESS IN SCHOOL CHILDREN BY PURE TONE AUDIOMETRY — 1958

			Cases of Hearing Loss revealed by audiometric test							B Family History		C Pregnancy			D Birth			E Associated Conditions			F Acquired Causes					G Findings and recommendation of School M.O.																	H Findings of Specialist															J Results of Re-testing		
			Bilateral			Unilateral																																																						
			Severe	Moderate	Mild	Severe	Moderate	Mild	Total cases with hearing loss	Deafness	Unknown congenital cause	Rhesus factor Kernicterus	Toxaemia	Prematurity	Anomalous growths, etc.	Birth trauma	Anoxia after b.	Cerebral palsy	Speech defect	Chest complications	Meningitis	Other I.D.	Trauma	Otitis Media	Unknown	No. examined by S.M.O.	Nil-leave	Nil-observe	Wax	Otorrhoea	Catarrh	Tonsils big or infected	Adenoids big	Complaint of deafness only	Tonsils and adenoids big	Ears not quite normal	Refer to family doctor	R.S.6.	R.S.7.	Backward	Attending family doctor	Attending otologist	No. seen by specialist	Tonsils enlarged	Tonsils and adenoids	Tonsils, adenoids and sinuses	Otosclerosis	Middle ear deafness	Simple ear toilet required	Hearing aid required	For auditory training	Nerve deafness	Proof puncture	Adenoids only	Sit at front of class	Leave alone	Observe	Normal	Improved	Observe further
			a	b	c	d	e	f																																																					
Routine group tested in 1958 — newly discovered hearing loss (Born 1952/3)	Bilateral	a	1						1					1												1		1																																
		b		11					11					1					1		1			1		11			2		3	3			1			3	3		2		6		3	1		1				1					1	3		
		c			73				73				2	1				1	2					6	1	62		19	4		13	2	8		4		3	7	5		4		9		3	1					1			3				4	1	1
	Unilateral	d				2			2																	2							1					1	1				2			2		1												
		e					4		4		1													1		2			1										1				1					1						1						
		f						98	98	1			3	7					1		1			4		90	2	29	10	2	25	5	2		2		3	8	3	1	6	1	6		1			1					1	2				6	3	
									189	1	1		5	10				1	4		2			12	1	168	2	49	17	2	41	10	11		7		6	19	13	1	12	1	24		7	4		4			1	1	1	6			1	13	4	1
Routine group tested in 1958 — deafness already known (Born 1952/3)	Bilateral	a																																																										
		b		6					6			1			1		1		1	1						6			1		1		1		2			1	2		2	1	2							1	1							1		
		c			9				9	1														2		9		1		1	1	2			1				1		4	1	4		2			2										1		
	Unilateral	d																																																										
		e					2		2														1	1		1																1	1					1												
		f						18	18				1											6		18		5	2	1	2	1			1		1	1	1		3	3	4		1													2		1
									35	1		1	1		1		1		1	1			1	9		34		6	3	2	4	3	1		4		1	2	4		9	6	11		3			3		1	1							4		1
Cases other than routine group — newly discovered deafness	Bilateral	a																																																										
		b		10					10	2									1					3		8			1		1	1						6					8		1	1	1	2	1	2	1						1			1
		c			20				20	1														2		19	2	5	3	2	1	1	1		2	1	1	2		1	1		5								1			1	1	1	1	1	1	
	Unilateral	d				1			1															1		1												1					1					1												
		e					3		3																	2					1					1		1					—																	
		f						36	36	4													1	3		31	1	16	3	1	3	1	1	1	1			4	2		1		1	1														2		
									70	7									1				1	9		61	3	21	7	3	6	3	2	1	3	2	1	14	2	1	2		15	1	1	1	1	3	1	2	2			1	1	1	2	3	1	1
Cases other than routine groups — deafness already known	Bilateral	a	3						3															1		2																2	3							1	1									
		b		8					8	1						1						1		4		5						1			1	1		3	1				4					1		1	1						1			
		c			8				8															4		8		1			2		1					1			1	3	5		1									1						
	Unilateral	d				3			3		1												1			2																2	3														1			
		e					5		5												1			2		2		2													1		—																	
		f						9	9															1		9		2		1			1		1				1		1	4	5						1										1	
									36	1	1					1					1	1	1	12		28		5		1	2	1	2		2	1		4	2		3	11	22		1			1	1	2	2			1			2		1	
			4	35	110	6	14	161	330	10	2	1	6	10	1	1	1	1	6	1	3	1	3	42	1	291	5	81	27	8	53	17	16	1	16	3	8	39	21	2	26	18	72	1	12	5	1	11	2	5	6	1	1	8	1	1	5	20	6	3